Southport and Ormskirk Hospital NHS Trust

AGENDA
BOARD OF DIRECTORS' MEETING

To be held at 0900 on Wednesday 01 July 2020

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
TB102/20 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB103/20 (D)	**Declaration of Directors' Interests concerning agenda items** *Purpose: To record any Declarations of Interest relating to items on the agenda:*	*No*	*Chair*	
TB104/20 (D)	**Minutes of the previous meeting** *Purpose: To approve the minutes of the previous meeting* held on 03 June 2020	No	*Chair*	10 mins
TB105/20 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and approve completed actions.*	*No*	*Chair*	
STRATEGIC CONTEXT				**0910**
TB106/20 (V)	**Chair's Update** *Purpose: To **receive** an update on key issues from the Chair*	No	Chair	10 mins
TB107/20 (D)	**Chief Executive's Report** *Purpose : To **receive** an update on key issues from the Chair*	No	CEO	10 mins
RISK AND GOVERNANCE				**0930**
TB108/20 (D)	**Audit Committee** • Minutes from the meeting held on 15 April *Purpose: To **note** the minutes from the Audit Committee*	Yes	Chair	5 mins
TB109/20 (D)	**Board Assurance Framework** *Purpose : To **receive** the Board Assurance Framework*	*No*	*ADCG*	15 mins

TB110/20 (D)	**Corporate Risk Register** a) Extreme Risk Register b) Covid 19 Risk Register *Purpose : To receive the Risk Register*	*No*	*DoN*	10 mins
PERFORMANCE AND GOVERNANCE				**1000**
TB111/20 (D)	**Finance, Performance and Investments Committee** • AAA Highlight Reports • FPI minutes from meeting held 26 May 2020 *Purpose : To **receive** the reports for information and assurance and receive items of concern escalated to the Board*	No Yes	*Cttee Chair*	5 mins
TB112/20 (D)	**Integrated Performance Report (IPR)** *Purpose: To **receive** the IPR and consider any issues stemming from the report*	*No*	*EMT*	15 mins
TB113/20 (D)	**Finance Report** *Purpose : To **receive** the finance report for discussion and assurance*	*No*	*DoF*	10 mins
	COMFORT BREAK 10 mins			
WORKFORCE				1040
TB114/20 (D)	**Workforce Committee** • AAA Highlight Reports • Workforce Committee minutes from meeting held 27 May 2020 *Purpose : To receive the reports for information and assurance and receive items of concern escalated to the Board*	*No* *Yes*	*Cttee Chair*	5 mins
TB115/20 (D)	**Safe Nursing & Midwifery Staffing Report (bi-annual report)** *Purpose: To receive the Safe Nursing and Midwifery Staffing Report*	*No*	*DoN*	10 mins
QUALITY & SAFETY				**1055**
TB116/20 (D)	**Quality and Safety Committee** • AAA Highlight Reports • Quality and Safety minutes from meeting held 26 May 2020 • *Purpose : To receive the reports for information and assurance and receive items of concern escalated to the Board*	*No* *Yes*	*Cttee Chair*	5 mins

TB117/20 (D)	**Quality and Safety Reports** a) Quality Improvement Plan b) CQC Progress Report c) Medical Director's Covid 19 presentation *Purpose : To receive the Quality and Safety update for information and assurance*	No	DoN / MD	20 mins
TB118/20 (D)	**Infection Prevention and Control Assurance Framework** *Purpose: To receive and note the Infection Prevention Control Assurance Framework*	*No*	*DON*	10 mins
ITEMS FOR APPROVAL				**1130**
TB119/20 (D)	**Annual Freedom to speak up report** *Purpose: To receive and note the annual report*	No	DoN/ FTSUG	5 mins
CONCLUDING BUSINESS				**1135**
TB120/20 (V)	**Questions from Members of the Public** *Purpose: To respond to questions from members of the public that received in writing in advance of the meeting.*		Public	5 mins
TB121/20 (V)	**Message from the Board** *Purpose: To approve the key messages from the Board for cascading throughout the organisation*		Chair	3 mins
TB122/20 (V)	**Any Other Business** *Purpose: To receive any urgent business not included on the agenda*.	Chair		2mins
	Date and time of next meeting: **0900, Wednesday 02 September 2020**	**Chair**		***1145 close***
RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC				
	The Trust Board resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	**Chair**		

Chair: Neil Masom

NHS
Southport and Ormskirk Hospital
NHS Trust

Register of Interests Declared by the Board of Directors as at 26 June 2020

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
ARMSTRONG-CHILD Mrs Trish	Chief Executive Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**16 December 2019**
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 September 2017**
BRICKNELL, Dr David	Non-Executive Director	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust** **Trustee at The Rainford Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**Nil**	**20 February 2020** **27 March 2020**
CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**27 February 2020**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

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			personnel							
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**Nil**	**Nil**	**Nil**	**Project Adviser: Hospice of the Good Shepherd** 2017 to date **Specialist Adviser CQC** 2015 to date **Macmillan Cancer Information & Support Specialist** 2017 to date	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**9 July 2019**
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**31 January 2020**
KATEMA Mrs Sharon	Associate Director of Corporate Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**02 December 2019**
LEES Ms Bridget	Director of Nursing, Midwifery and Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Spouse employed as a Pharmacy Technician**	**Nil**	**Nil**	**7 February 2020**

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MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd**	**CQC Holdings Ltd** (manufacturer of textile products) **JSSH Ltd**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 February 2020**
PATTEN, Ms Therese	Deputy Chief Executive/Director of Strategy	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**Nil**	**Nil**	**Nil**	**4 February 2020**
POLLARD Mr Graham	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee at Alder Hey Children's Kidney fund**	**Nil**	**Nil**	**Employed by the University of Liverpool**	**27 April 2020**
ROYDS, Mrs Jane	Director of Human Resources& Organisational Development	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**24 February 2020**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Member of the Board of Trustees for Age Concern Central Lancashire**	Nil	**Nil**	**Nil**	**Trustee – Age Concern**	**5 February 2020**

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SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health** **Trustee of the Southport and District Medical Education Centre Fund** **Trustee of the Ormskirk and District Post Graduate Medical Trust.**	**Nil**	**Nil**	**Nil**	**19 February 2020**

Minutes of the Board of Directors' Meeting
held on Microsoft Teams
Wednesday 03 June 2020
(Subject to the approval of the Board on 01 July 2020)

Members Present

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

In Attendance

Mr Steve Christian	Chief Operating Officer
Mr Tony Ellis	Communications and Marketing Manager
Mrs Pauline Gibson	Non-Executive Director Designate
Mrs Sharon Katema	Associate Director of Corporate Governance
Mr Graham Pollard	Non-Executive Director
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Juanita Wallace	Interim, Assistant to Associate Director of Corporate Governance
Mrs Lynne Eastham	Head of Midwifery (item 96/20 only)
Mrs Uma Karthikeyan	Consultant Obstetrician and Gynaecologist (item 96/20 only)

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB079/20	**Chair's Welcome and Note of Apologies**	
	Mr Masom welcomed all in attendance and noted apologies from Dr Hankin who would be joining the meeting later. He outlined that the meeting would be forward to align with the Trust moving into Phase 2, Business with COVID19. With regards to accessibility of meetings to the public, Mr Masom highlighted that whilst no questions had been received from members of the public, plans were now in place to ensure that members of the public would be able to join the virtual meetings from July through MS Teams broadcast.	
TB080/20	**Declaration of Directors' Interests concerning agenda items**	
	There were no declarations of interests in relation to the agenda items. **RESOLVED:** The Register of Directors' Interests was **approved.**	
TB081/20	**Minutes of the previous meeting held on 06 May 2020**	
	The Board reviewed the minutes of the meeting held on 06 May 2020 and approved them as a correct and accurate record of proceedings subject to the	

	following amendments: • Minute ref. TB061/20 so it reads, "The system had initiated its response to the elective phase which would be led by James Sumner, Chief Executive at Mid Cheshire Hospitals NHS Foundation Trust" • Minute ref. TB061/20 so it reads. "Service reconfigurations approved through the Hospital Cell such as the mutual aid agreement with Alder Hey for out of hour's paediatric emergency care, would remain in place and could only be changed through the COVID formal process" • Minute ref. TB062/20 so it reads, "Mr Singh advised that there was a bid on a national level to carry out research into factors affecting BAME. He advised that there was a quick turnaround time for Trusts willing to take part in this research, with details being expected to be available by mid-June. Dr Hankin to consider this as he understood that neighbouring Trusts had larger cohorts and understanding around the antibody response and viral shedding." • Minute ref TB067/20 so it reads, "Mr Singh asked if the Trust was missing any non-cancer urgent and non-urgent cancer referrals as patients could choose not to attend lest they potentially risk exposure to the virus and any reassurance that was given to the patients." **RESOLVED:** The Board **approved** the minutes as an accurate record of proceedings held on 06 May 2020 subject to the noted comments.	
TB082/20	**Matters Arising and Action Logs**	
	There were no matters arising from previous minutes. The action log was updated reflecting progress made in discharging outstanding actions.	
STRATEGIC CONTEXT		
TB083/20	**Chair's Report**	
	Mr Masom presented his report which detailed the activities he undertook since the previous meeting including updates from North West Region System and Governance during Covid-19 pandemic. **RESOLVED:** The Board **received and noted** the Chair's update.	
TB084/20	**Chief Executive's Report**	
	Mrs Armstrong-Child presented her report which provided an overview of specific activity and issues that occurred in the Trust since the previous meetings. She outlined that large banners thanking the public for their support over the last few months were hung outside the hospital site as acknowledgement to the number of volunteers who are interested in volunteering across both sites.	

Maintaining patient flow through the Emergency Department (ED) remained a significant challenge to the Trust following the revision of emergency flow pathways. Whilst the Trust recently recorded the highest number of ED attendances with 182 people, maintaining social distancing requirements during periods of high attendance was proving challenging.

The Southport and Ormskirk Improvement Board (SOIB) would be resuming each quarter and would be focussed on progression with the CQC action plan. The Trust had also received support from a CQC inspector who had been redeployed for two days a week into the Trust.

With regards to the reportable issues log, one serious incident relating to a confirmed MRSA bacteraemia, which would be reviewed and monitored by the Infection Prevention and Control Committee, had been reported. The historic backlog of Level 4 and Level 5 complaints has been cleared with the longest complaint currently at 33 days.

The Southport and Ormskirk Hospitals Charity launched a £50,000 urgent welfare appeal for staff, patients, and volunteers in April. This has been followed up with a number of stories about fundraising by people in our local community including Seren Farrington, aged 8, from Southport, who raised £1,500 from "commissions" for artwork from friends and relatives around the world. The Trust took the opportunity of the last clap for carers on Thursday to say thank you to the community for all their support.

Work on reviewing the extreme risks on the Risk Register was progressing. Since taking up the chair of the Risk and Compliance Group the CEO requested all risk leads to review action plans and ensure that all mitigations were up to date. These were presented at the Risk and Compliance Group who approved the downgrade of several key risk ratings resulting in three extreme risks remaining on the register.

In response to Dr Bricknell query on feedback around winter pressures and if there was any information relating to steps taken by Trust and the Commissioners, Mr Christian advised that Ms Fagan, Programme Director Unplanned and Emergency Care, had been tasked with carrying out an exercise around winter pressures. However, this had been superseded by COVID. Notwithstanding this, a formal evaluation to support winter with COVID was underway and would be presented to the Board, through the relevant committees, once finalised.

Mr Ellis commented on the quality of the media communications and in particular the way the Trust has used social media as a way to get the message to the public of what things are like in the hospital. Plans were in place to produce more of these types of videos. It was noted that consideration would need to be given on the viability and delivery mode of holding the Open Day.

RESOLVED
The Board **received** the Chief Executive's Report

TB085/20	**Strategy Update**	
	Item redacted, commercially sensitive. **RESOLVED** The Board **received** the Strategy updates	
Gold Command Update		
TB086/20	**COVID19 Update**	
	Item redacted, commercially sensitive. **RESOLVED** The Board **received** the Covid 19 updates	
TB087/20	**COVID19 Risk Register**	
	Item redacted, commercially sensitive. **RESOLVED** The Board **received** the Covid 19 updates	
PERFORMANCE AND GOVERNANCE		
TB088/20	**Finance, Performance and Investments Committee**	
	Mr Pollard presented the AAA highlighted report and the minutes from the Finance, Performance and Investments Committee. With regards to the Alert from the Committee regarding the increase in staffing numbers, Mr Masom highlighted that this had also been raised on the NED calls. It was noted that the Executive Team members were working on refreshing the workforce strategy and re-aligning this with the financial oversight. The meeting discussed the need to review and resolve this and requested the Executive Team to review from a workforce and financial perspective and provide feedback to the Board. **ACTION :** The Executive Team to provide an update to the Board through FPI of a 360 overview on aligning workforce with financial oversight. **RESOLVED:** The Board **received** the minutes and AAA Highlight report from the Finance, Performance and Investments Committee.	**DoN**
TB089/20	**Integrated Performance Report (IPR)**	

	Mrs Armstrong-Child introduced the new format of the report advising that the report would continue to evolve over time with each Executive Director providing an overview of their relevant sections. It was noted that whilst there were a couple of indicators that needed further refining the Ward to Board dashboard, which was still a work in progress, would be pivotal in the intelligence provided to the Board. Each indicator had a Statistical Process Control (SPC) chart and commentary and some indicators were included as improvement measures for the four Quality Improvement properties. Mrs Gorry commented that, whilst the dashboard matrix still required some work, it was looking good. The Ward based matrix will require a level of understanding. Mrs Armstrong-Child commented that our job as a Board was to set the standard of what good looks like and to ensure that there is an understanding of what wards are being judged on. Dr Hankin outlined that the decrease in performance around repairs to fractured neck of femur injuries at the height of COVID19 was due to the fact that there was a single theatre in operation for all emergencies. This position had now improved as there was a now a dedicated theatre and this should result in an increase in performance. Mr Birrell commented that the drop in turnaround time for Complaints was not reflected in the IPR. Ms Lees advised that the IPR data was for April adding that the future reports would reflect the turnaround time falling in line with the 40 day trajectory. **RESOLVED** The Board **received** the IPR report and considered any issues stemming from the report.	
TB090/20	**Finance Report including**	
	Mr Shanahan presented the Financial report showing the financial position for month 1 2020/21. He outlined that all Trusts were continuing to operate within a revised financial framework and for the first four months of the financial year all Trusts would break-even due to a "top up" fund being provided by NHSE/I and additional funding for COVID19. The Trust had achieved a break-even position in month 1 and did not require the full top up due to expenditure being significantly lower that budget. Mr Shanahan advised that the Trust submitted Month 12 unaudited accounts on 11 May 2020 to NHSE/I. Following the revaluation of assets and review of provisions in terms of balances the trust reported a £3.6 m variance to the control total. The External Auditors, Mazars, had concluded that most of work, excluding revaluation of assets, was mainly due to national issues. He added that the Trust had submitted accounts and responses to any questions around re-evaluation of assets and this had been accepted. With regards to the dispute with Sefton CCG, Mr Masom sought clarification on whether this amount would be rolled into the next financial year. Mr Shanahan responded that we would have normally received the end of year statement by now but this has been delayed due to COVID19. Mr Birrell advised that similar comments are made every year and that the sign off of accounts with the gap	

	will be carried out by the CCGs in due course. **RESOLVED** The Board **received** the finance report for discussion and assurance	
TB091/20	**Capital Plan 2020/21, including 5 year capital programme**	
	Mr Shanahan presented the 2020/21 Capital Plan report which outlined the process followed to achieve a capital plan that is compliant with the Trust's statutory Capital Resource Limit (CRL) target and addressed the Trust's high risks. **Item redacted, commercially sensitive.** **RESOLVED:** The Board **approved** the 20/21 capital programme	
TB092/20	**Redacted**	
	Item redacted, commercially sensitive. **RESOLVED** The Board **approved** the recommendation.	
TB093/20	**Redacted**	
	Item redacted, commercially sensitive. **RESOLVED** The Board **approved** the recommendation	
QUALITY AND SAFETY		
TB094/20	**Quality and Safety Reports**	
	Dr Bricknell presented the minutes and AAA highlight report from the Quality and Safety Committee. He drew attention to the Alert relating to the transfer of the responsibility for DoLS to the hospital which had been postponed from October adding that the rise in cases could pose significant challenges once the Trust was given full responsibility. It is the responsibility of all managers to ensure that staff are up to date with their clinical training. Mrs Royds, Ms Lees and Dr Hankin have met with Ms Gunn to discuss this going forward. In response to Mr Masom's question Mrs Armstrong-Child advised that she will	

	be the incoming Chair of the Risk and Compliance Committee and the Committee will be reviewing the Risk Register. It is not clear as to why some of the extreme risks that have been included on the Register and this will be challenged going forward. We need to look at each risk and hone down what is it about and once this has been done can we address the risks. Dr Bricknell advised that this is one of the reasons why he included it as an Alert. Dr Bricknell is concerned that a never incident could occur if nothing is done and this could be a catastrophic failing of the Board. Ms Lees advised the meeting that the risk register comes via the Governance structure and was part of the recommendations around Well Led. This has been raised by the CQC a number of times but has still not been resolved. The ward dashboard will show a breakdown of training and we will have oversight of this going forward via the Ward to Board dashboard. This will be a focus over the next couple of months. **RESOLVED:** The Board **received** the reports for information and assurance and received items of concern escalated to the Board	
TB095/20	**Quality and Safety Update**	
	a) CQC Well-Led Self-Assessment Progress Update Ms Lees presented the CQC Well-Led self-assessment progress report reflecting the progress made against the Well Led domain since the publication of the CQC inspection report in November 2019. It was noted that whilst work had continued since the last inspection, there had been no formal review or update specifically on the Well Led Domain reported into the Board. Mrs Armstrong-Child advised that, following last year's CQC visit work has been carried out with Aqua and this included self-assessments around Well Led. Mrs Gorry sought clarification on the NEDs role within the process and how they could contribute and be more effective in the coming months. It was noted that it is not always possible to provide evidence of innovations that have been put into place. Ward visits, which sits within Well Led as well as the role of the NEDs, needs to be re-instated and Ms Lees was asked to provide her thoughts on what ward visits would like going forward. The Board needs to discuss how this will be measured. It was suggested that recommendations be included in the annual Work Plan. Ms Lees commented that there was a need to assess where the organisation is at the moment as well as developing a formal plan. She highlighted that if the agreed recommendations could be incorporated in the reporting structures.	

This work would be discussed as part of the review into the organisation structure which links in with the revision and refreshing of the Committee terms of reference.

The Trust was in the process of launching a new patients' experience strategy and it is hoped that this will be presented to the Board before the launch. Ms Lees advised that the team is in the final cycle and it is important that the Trust has strategies in place that underpin this. NHS Academy is currently working with the Trust to draw up an action plan to underpin this strategy. Ms Lees will circulate the action plan for final comments.
The owner of the Use of Resources document was challenged to present their document in the same format, highlighting the three elements of the plan.

RESOLVED:
The Board **received** the reports for information and supported the recommendations. It was agreed that an update would be presented in three months.

b) Annual Safeguarding Report
Ms Lees presented the Annual Safeguarding Report which provided an overview of safeguarding activity and as well as assurance to the Trust Board of the robust processes in place to safeguard those who use Trust services as well as highlighting areas of challenges in safeguarding provision.

Dr Bricknell commented that the report provided a full and candid review and revealed the shortcomings whilst providing a review of progress made.

Mr Singh requested clarity on whether or not the safeguarding team was making a difference to outcomes across the Trust. Mrs Armstrong-Child advised that this is covered across a number of Committees. The Board needs to look for assurance from the various committees that what is being reported as being done has been done. Safeguarding is a big issue and the Trust needs to get this right. In response to the question regarding the significant increase in DoLS applications, the Board was advised that increase in applications was in line with national figures. The Board took assurance that patients were detained in line with legislative requirements and that regular audits were carried out to ensure full compliance.

With regards to comments on the Executive Summary providing sufficient information, Ms Lees advised that there were concerns around the increase in adult safeguarding concerns against the Trust but was unable to find out the outcomes. Following discussions around the review of cases and feedback to local authorities it was noted that this work had been undertaken as part of the work around discharges. Mrs Armstrong-Child commented that patient surveys had highlighted opportunities of improvements around discharges and these would be included in the Quality Improvement Programme The Trust would be using the QI approach to look into and set targets for coming year.

	RESOLVED The Board **received the Annual Safeguarding Report.** **c) Learning from Deaths Report** This was deferred to July 2020 **d) Medical Vacancies** Dr Hankin presented the Medical Vacancies report which advised of the Trust's current position and the challenges going forward. Dr Hankin highlighted that the challenges with medical vacancies as the UK relied on foreign doctors to fulfil the medical vacancy requirements. Dr Hankin advised that the Trust needs to consider the services going forward as the bulk of the Trust's overspend was around bank and agency staff which would add to these costs. It was noted that there was a big differential between agency rates and NHS rates. Mr Christian and Dr Hankin are working towards being able to build a network provider but this need to be done appropriately. The Trust needs to be part of the wider network. Dr Hankin has emailed the Regional Medical Director highlighting the need for a national approach around locum costs. Mrs Gibson supports Dr Hankin's piece of work to understand how everything joins up. The overspend on Agency is the outcome of the root problem and we need to understand the gap. Recruitment and retention as well as sickness absence and performance issues also need to be taken into account and be included in the overarching workforce piece otherwise we are not looking the root cause. In response to Mrs Gorry's question around patient safety in the run up to winter, and the comment around keeping locums on short term contracts, Dr Hankin advised that it would be better to offer 3 to 6 months contracts but that this would depend of the quality of the individual as well as the demands at the time. He added that the Trust would deliver a safe service going into winter and taking into account the possibility of a second spike in COVID19. The Board needs to be aware of the potential safety issues that could occur in some of the specialist services if not action is taken. Dr Hankin and Mr Christian are currently working with partners to ensure that the Trust is more proactive going forward. **ACTION**: Dr Hankin will review rota compliance and provide an update on compliance with rotas and gaps. **RESOLVED:** The Board **received** the update on Medical vacancies	
TB096/20	**Maternity Report**	
	Mrs Eastham and Dr Karthikeyan joined the meeting Mrs Eastham Dr Karthikeyan delivered a presentation which provided an overview and update on Maternity Services.	

	The report focused on 3 key priorities namely: • Safety • Choice • Personalisation in maternity services. The report also looked at how the Service measures and monitors its success. The drop off in the PDR rate pre COVID19 could be attributed to sickness in the area. There are some issues around the use of temporary staff on the mid-grade and consultants rotas but this is being managed. There have been recruitment issues around consultant roles, however 6 new consultants have been recruited and they are working on the emergency rota. A new job plan for consultants has been put into place Resources have been allocated to audit each metric and identify lessons learnt as well as ensuring that these lessons are being implemented. Action plans have been put in place following feedback received from a recent staff survey around the quality of PDRs as well as staff involvement as well as to deal with issues around mandatory training. Following a brief discussion, it was noted that the actions from the CQC actions had been fully embedded into the service. The Board thanked Mrs Eastham and Dr Karthikeyan for the presentation and noting that the Trust compared favourably to the national figures and staff were aware of the process to follow when raising concerns. **RESOLVED:** The Board **received** the report for assurance *Mrs Eastham and Dr Karthikeyan left the meeting*	
WORKFORCE		
TB097/20	**Workforce Committee**	
	Mrs Gibson presented the minutes and AAA highlight report from the Workforce Committee. The following alerts were brought to the attention of the Board: • There was an increase in the number of staff absences due to stress and anxiety prompting the Committee to request a report outlining how this was being managed. • A more in depth report has been requested around staff turnover including medical vacancies. The NHS Professional contract continued to be closely monitored as performance remained below the KPIs detailed in the contract. The Board was advised that a discussion had taken place around the best	

	company to assist with international recruitment. This included discussions with procurement on best way to move forward. This discussion would be continued at the next meeting. **RESOLVED:** The Board **received** the Workforce Committee Reports.	
RISK AND GOVERNANCE		
TB098/20	**Draft Annual Governance Statement**	
	Mrs Armstrong-Child presented the draft Annual Governance Statement which provided a summary of the effectiveness of the systems of internal control and how these were managed during the previous financial year. It was noted that the AGS would be independently audited by the External Auditors, Mazars and would be presented to the Audit Committee for approval. It was agreed that any specific comments on the AGS would be forwarded to Mrs Katema. **RESOLVED:** The Board **received** the draft Annual Governance Statement	
CONCLUDING BUSINESS		
TB099/20	**Message from the Board**	
	The Board agreed messages to be circulated across the organisation which included the marked improvement in clearing the backlog of historical complaints and increased support from nursing students. It was agreed that the relaunch of the strategy would need to flow into the revised messages to the workforce.	
TB100/20	**Any Other Business**	
	Mr Masom advised that the next meeting would be held on 17 June following the Audit Committee and would be focussed on formally approving the Annual Reports and Accounts..	
	There being no other business, the chair thanked all for attending and brought the meeting to a close at 1259. The next Board meeting would be held on **Wednesday 01 July at 8am.**	

Board Attendance 2020/21												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓	✓	✓									
Trish Armstrong-Child	✓	✓	✓									
Jim Birrell	✓	✓	✓									
David Bricknell	✓	✓	✓									
Bridget Lees	✓	✓	✓									
Julie Gorry	✓	✓	✓									
Terry Hankin	✓	✓	✓									
Therese Patten	✓	✓	✓									
Graham Pollard	✓	✓	✓									
Steve Shanahan	✓	✓	✓									
Gurpreet Singh	✓	✓	✓									
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	✓									
Steve Christian	✓	✓	✓									
Jane Royds	✓	✓	✓									
Sharon Katema	✓	✓	✓									
✓ = In attendance A = Apologies												

BOARD OF DIRECTORS (Part 1)
Action Log updated 26 June 2020

NHS Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB068/20	06 May 2020	**Use of Resources**	The Use of Resources self-assessment to be presented at the July Trust Board.	**DoF / CEO**	6 May 2020	3 June 2020	**June Update:** Included on agenda. Action completed **July Update:** To be presented first at July's F,P&I committee then Board.	**Green**
TB085/20	03 June 2020	**Strategy Update**	Mr Masom, Mrs Armstrong-Child and Ms Patten to obtain clarity of the road map as well as around funding	**Chair / CEO / DCEO**	01 July 2020	01 July 2020	**June Update:** An update to be presented at July meeting.	**On Agenda**
TB086/20	03 June 2020	**COVID19 Update**	Dr Hankin to present a breakdown in the number of excess deaths up to age of 60	**MD**	01 July 2020	01 July 2020	**June Update :** To provide update **July Update : To be presented at July Board**	**On Agenda**
TB088/20	03 June 2020	**Finance, Performance and Investments Committee**	The Executive Team to provide an update to the Board through FPI of a 360 overview on aligning workforce with the financial oversight.	**DoN**	01 July 2020	01 July 2020	**July Update :** The work to address this action is progressing. An update will be presented at the September meeting	**Green**

BOARD OF DIRECTORS (Part 1)
Action Log updated 26 June 2020

Southport and Ormskirk Hospital NHS Trust

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
TB108/19	Nov 2019	**Finance Report**	EPMA funding allocation. Outline progress plan to come back to Board in January	**DOF**	Jan 2020	Feb 2020	**January Update:** item deferred to February as there is a special Board convened to discuss and approve the Revised Capital Plan and the Forecast Outturn Position. **February Update:** The project Group has been established and initial meeting with System C product expert has been held. A Project Plan will be presented to the IMT Committee on 28 February 2020. **June Update:** Item included on agenda. **Action Completed** **July Update:** Business Case on agenda	BLUE
TB063/20	06 May 2020	**COVID-19 Risk Register**	The scoring of Risk 2220 Constitutional standards to be reviewed by Gold Command at the next update.	**ADCG**	6 May 2020	3 June 2020	**June Update:** The Risk Register was presented Gold Command for review and the risk scoring has been updated.	BLUE
TB067/20	06 May 2020	**Integrated Performance Report**	Mr Ellis, in consultation with Mr Christian and Dr Hankin, to draw up formal correspondence to GPs regarding patient access to referrals	**COO**	6 May 2020	3 June 2020	**June Update: Action completed.**	BLUE
TB072/20	06 May 2020	**Board Assurance Framework (BAF)**	Future agendas to be re-sequenced to ensure that there was sufficient time for discussion of future reports	**ADCG**	6 May 2020	01 July 2020	**June Update:** Agenda will be re-sequenced each time the BAF and Risk Register are presented. Action completed	BLUE
TB095/20 a)	03 June 2020	**Quality & Safety Update** **a) CQC Well Led Self Assesment**	Board Development to be discussed at the July Board Meeting		01 July 2020	01 July 2020	**June Update :** To be discussed at July Board meeting. Action Completed	BLUE

BOARD OF DIRECTORS (Part 1)
Action Log updated 26 June 2020

Southport and Ormskirk Hospital NHS Trust

TB072/20	06 May 2020	**Fit and Proper Person's Test (FPPT) Annual Report**	Mrs Katema to circulate the annual self-declaration to Board members.	**ADCG**	01 July 2020	01 July 2020	**June Update:** To be sent to all directors by 3 June 2020. Action completed	**BLUE**

Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 July 2020**
Agenda Item	**TB107 /20**	**FOI Exempt**	**No**
Report Title	**CEO Report**		
Executive Lead	Trish Armstrong-Child, Chief Executive Officer		
Lead Officer	Trish Armstrong-Child, Chief Executive Officer		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The attached briefing paper provides an update on some high level updates since last Trust Board

Recommendation

The Board is asked to receive the report for information.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Trish Armstrong-Child, CEO	Trish Armstrong-Child, CEO

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

Staff and patients played their part in a major international development in the fight against the Covid-19 coronavirus.

The results of the recovery trial, which involved patients recruited by us, suggest the low-cost steroid dexamethasone reduced death rates among the most severely ill Covid-19 patients admitted to hospital. The risk for patients placed on ventilators was cut by a third, and the risk for patients on oxygen was reduced by a fifth.

Thank you to Dr Ashar Ahmed, Clinical Director of Medicine, and co-investigators Dr Arvind Nune and Dr Stefania Pintus, as well as the research team, medical team, Covid wards and pharmacy, for giving our patients the opportunity to take part in this important work.

Our twice monthly staff recognition scheme will relaunch on 25 June.

2. News and Developments

2.1 COVID-19 virus

The Trust continues to see plateauing numbers of covid positive inpatients at Southport with fewer numbers of positive patients in Critical Care on a week by week basis. However, the NHS remains in Level 4 national incident status with the Trust continuing in command and control mode within the Hospital Cell. Gold command meetings within the organisation continue to be in place two days per week with the Phase II Board continuing to meet three days per week.

The past month has seen the Trust start to address a number of the long wait elective surgical cases in a number of Specialties. Each CBU continues to work on the Phase II plans approved in the Phase II Board and Gold Command with the view to restarting elective outpatients in a safe manner.

National guidance around swabbing of patients prior to elective surgery has been implemented with the requirement for 14 days isolation prior to the TCI date. This is challenging with many patients feeling unable to isolate due to commitments and the length of time required. Current guidance is that patients who decline a date for a procedure due to covid fears or failure to isolate must remain on Waiting Lists; this will have an impact on our waiting times.

The numbers of A+ E arrivals are increasing. The month saw a number of surges in attendances culminating in the third highest of 2020 in early June. Work around system wide admission avoidance continues with the focus on streaming and signposting patients appropriately through 111 when contacted. The Trust has completed a capital bid to enable us to move into phase 3, which will see us increasing our elective programme whilst preparing for winter. An outcome on the capital bids is still awaited.

3. Trust News

3.1 Trust News
Appointments made since last Trust Board:

Dr Craig Rimmer, ED Consultant
Dr Richard Taylor, ED Consultant

4. NHSI/E Meetings

4.1 Southport & Ormskirk Improvement Board
The Southport and Ormskirk Improvement Board (SOIB) met on the 4th of June. This meeting will be chaired by NHSi Regional Medical Director and the Executives provided the Board with an overview of our COVID 19 response, our integrated performance dashboard and an update on our progress with the CQC action plan.

5. Reportable Issues Log

Issues occurring between 29/05/2020 to 25/06/20

5.1 Serious Incidents and Never events
One STEiS reported in Month
- Pre term infant.

5.2 Level Four and Five Complaints
One reported in Month. Concerns were related to hospital admission and communication.

5.3 Regulation 28 Reports
No concerns were detailed in HM Coroner reports.

5.4 Whistleblowing
No internal cases to report

6. Media Coverage

6.1 Virus busters! Life-saving research at town's hospitals plays vital part in disease breakthrough (Champion - 24/6/20)

6.2 Youngsters painting are sold round world to raise money for hospitals (Champion - 24/6/20)

6.3 Hospitals to hold recruitment event (Champion - 24/6/20)

6.4 Changing roles! Champion takes behind the scenes look at how NHS staff coped at Southport and Ormskirk hospitals as pandemic struck (Champion - 17/6/20)

6.5 Hospitals charity in appeal for community ambassadors (Champion - 10/7/20)

6.6 Our intensive care video for patients has been widely shared online, including by the NHS Academy of Fab Stuff

7. Risk Register and Board Assurance Framework

The updated BAF and extreme risk report will be presented as an agenda item.

Trish Armstrong-Child
Chief Executive
Date 25/6/20

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB109/20**	**FOI Exempt**	**No**
Report Title	**Board Assurance Framework**		
Executive Lead	Trish Armstrong-Child, Chief Executive		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Board Assurance Frameworks, following a review during Q.2 by the accountable Executive Directors.

Executive Summary

There is recognition and acknowledgement that the revision and refresh of the BAF has not progressed at pace. However, the commitment to progress this remains. The current BAF continues to be reviewed on a monthly basis by the executive directors for their respective domains and has seen a change to the content and formatting of the BAF.

The current iteration was completed during June 2020 and is enclosed.

Recommendation

The Board is asked to **receive** the updated Board Assurance Framework

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
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- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Sharon Katema, Associate Director of Corporate Governance	Trish Armstrong-Child, Chief Executive Officer

Board Assurance Framework (BAF) Report

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO1** - Improve clinical outcomes and patient safety to ensure we deliver high quality services			**Risk Description** (*What could prevent the objective from being achieved)*	***If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety***
DATIX CODE	**2094**	**RISK ID:**	**1**		**Cause:** • Significant number of clinical staff vacancies • Clinical capabilities and competence, recruitment and retention problems, trust location and estate • Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies • Failure of national performance target (cancer, Referral to Treatment (RTT)) • Failure to reduce delayed transfers of care in the changing NHS environment **Potential Effect:** • Reputational damage leading to difficulty in recruitment. • High numbers of people waiting for transfer from inpatient care, particularly older people • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience feedback via Friends and Family Test and National Surveys • Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services **Potential Impact:** • On reputation. • Failure to meet contractual requirements. • Inability to deliver the best clinical outcomes for patients • Increased patient safety incidents, increased levels of patient harm, loss of commissioner and patient confidence in provision of services, enforcement action, prosecution, financial penalties, and reputational damage.
Assurance Committee	Quality and Safety Committee				
Executive Director	Director of Nursing/Medical Director				
Risk Appetite:	**CAUTIOUS**				

Risk Rating Tracker	Risk updated June 2020 and remains high	**Risk Scores:**	**Initial/Raw**	**16** **4x4** **(L x C)**	**Current**	**12** **3x4** **(L x C)**	**Target**	**8** **2x4** **(L x C)**

Controls	**Gaps in Controls**	**Remedial Actions**
Medicines Management Improvement Plan	Delivery against Medicines Management Improvement Plan due 2021/22	Action 1 – Delivery against Medicines management Improvement Programme **June 2020 Update:** The CQC 'Must Do' actions continue to be addressed during the Coronavirus pandemic. Perfect Ward App is currently being rolled out and will support the ward level checks and audits. The introduction of the Monthly Matron's Checklist on Perfect Ward is providing the project team with smart, reliable information with which to inform compliance levels, progress and areas requiring improvement. The data is to be triangulated with the information collated by the Pharmacy Assistant Technical Officers and Quality Matrons to provide additional insight.
Care of the Older Person Improvement Programme	Delivery against Care of the Older Person Improvement Plan due 2021	Action 2 – Delivery against Care of the Older people Improvement Programme **June 2020 Update:** The Covid-19 pandemic response has meant that almost all of the work on Older People's Care has been halted as lead clinicians were redeployed. It has however provided an opportunity for the leads to review the work as a whole to ensure the workstreams carried forward are more manageable, and still valid and appropriate to this forum. Progress has been made though in identifying different leads for the following workstreams; Enabling Environment, Home First, Nutrition & Hydration, Mouth Care, NG Feeding, Dementia & Delirium and Quality of Life Feeding
Recognising the Care of the Deteriorating Patient Including compliance with the National Structured Judgement Review method designed by the Royal College of Physicians	Delivery against Recognising Care of Deteriorating Patient due 2021	Action 3 – Delivery against Recognising Care of Deteriorating Patient Improvement Programme **June 2020 Update:** Resources are currently focused on the ratification of changes to the project through the governance process, the revision of milestones. The key focus will now be on: Observations and Escalation (Deteriorating Patient Workshop to be held in July 2020) and Clinical Pathways (focus on AKI).
Infection Prevention & Control Improvement Plan	Delivery against Infection Prevention & Control Improvement Plan due 2021	Action 4 – Delivery against Infection prevention control Improvement Programme **June 2020 Update:** The IPC team have been focussed on leading and

		supporting the Trust response to the Coronavirus recovery planning, although progress has been made against ANTT training. Improvements in blood culture contamination rate at 4.4% (lowest rate in the last 12 month period).Although limited in numbers, hand hygiene audits undertaken in Q1 demonstrated 100% compliance. Next month wards are being asked to monitor their own areas to avoid unnecessary movement between them. Wards are being asked to identify a hand Hygiene ambassador on each shift and that individual can audit and log and record any breaches to support the IPC compliance work.
Workforce Improvement Plan	High levels of clinical staff vacancies and high levels of agency usage Medical staff work plans not yet finalised	Action 5 – Nurse Establishment Review Action 6 – Finalising Medical Job Plans **June 2020 Update:** Trustwide Workforce Plan continues to be developed. Career pathway drafted to support recruitment to band 4 roles. Latest Nurse Establishment Review to be presented to Board July 2020. Nursing Recruitment & Retention Group halted due to Covid-19 – to be reinstated June 2020.
Winter Plan	Gaps in system-wide working e.g. social care High bed occupancy and reduced patient flow	Action 7 – Trust Patient Flow Improvement Programme **June 2020 Update:** Winter Planning will be discussed as part of the Trust's Phase 2 and 3
Training programme (mandatory and non-mandatory)	Gaps in some areas of mandatory training e.g. Resus Gaps in Clinical Skills Training delivery No dedicated funding to purchase equipment and consumables to support training	**June 2020 Update:** A Trust wide Clinical Competency Working Group was established Feb 2020 with an associated action plan. This is being monitored monthly through Risk & Compliance Group and Workforce Committee. Top 10 risks for all staff have been identified and a TNA is in progress. Role specific training reported monthly and monitored through CBU PRB's.
Governance processes around policies and guidelines	Out of date policies Issues with the quality of documentation	Action 8 – Establish Documentation Programme Action 10 – Ward Accreditation Programme Action 11 – Out of Date Policies **June 2020 Update:** Scoping on the documentation programme has stalled due to the pandemic. The Ward Accreditation programme has paused due to the pandemic but is due to recommence July 2020. A detailed plan on Policy management will be taken to QSC and RCG in July 2020.
Analysis of incidents, complaints and claims to identify areas of risk.	Evidence of lessons learned from incidents, complaints and audit	Action 9 – Enhancement of shared learning across CBU's **June 2020 Update:** Lessons learnt standardised format in development and will be produced monthly.
• Supervision and education of clinical staff across all professions. • Application of clinical pathways and guidelines. • Increasing R&D involvement across the organisation • Regulatory information provided to staff in update sessions • An integrated approach between corporate, operational and governance teams. • Quality Impact Assessments for all service changes and CIPs that are considered • Professional standard • Risk Management Strategy and culture • Freedom to Speak Up Champions in place across the Trust • Bronze, Silver, Gold Control for management of Coronavirus pandemic		
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance gained at operational tier – Level 1		
• Local and National Audit Programme/Audit Strategy • MDT approach to patient management • Directorate performance reviews • Monthly and Annual Mortality Reports to Mortality Operational Group and Trust Board		

• StEIS and Incident Reporting • Monthly CBU Quality and Safety Reports • Reports to Patient Flow Improvement Board • Clinical Revalidation • Patient feedback (FFT/Patient Surveys) • Quality Visits/Senior Walkabouts including focus on Patient Safety • Maintenance of CQC registration		
Reports and metrics monitored at Assurance Committees and/or Board – Level 2		
• Monthly Mortality Reports to Q&S and Board • Never events • Quality Strategy metrics • CQUINS • Internal audit metrics • High level performance metrics • Serious Incident Reporting Group • Freedom to Speak Up • Speak Up Champion (NED appointed by Board) • Integrated Performance Report • Monthly Safe Staffing Report • Quarterly and Annual Guardian of Safe Working Report		
Monthly Highlight Reports on 4 Key Quality Priorities to Q&S and Board	Pace of improvement against Quality Priorities	Actions 1, 2, 3, 4 as above **June 2020 Update:** See above
Incident data	Lack of testing of action plans following audits to ensure they lead to embedded change	Action 9 as above **June 2020 Update:** See above
Performance data	Lack of available benchmarking data across all services	
Independent / semi-independent		
CQC inspection visits	CQC Inspection identified regulatory breaches (Must & Should Do's)	Action 11 - Delivery of must and should do CQC actions **June 2020 Update:** SO Go See Visits to be reinstated in June 2020 to test progress against CQC Must and Should Dos
• External and Internal Audit Plans • GMC / NMC Reports • Royal College Reports / Visits • SHMI / RAMI • CQC Outlier Alerts • National Audits • Peer Reviews and accreditation. • R&D Performance • Regular meetings with NHSI/E/ CQC • Engagement meetings with CQC • CCG monthly quality and performance meetings • Quality Account		

Number of linked Risks: 2	1862 - Maintaining safe quality nursing care with current level of nursing & HCA vacancies 2130 - Clinical competence of the multi-professional patient facing workforce	**Number of linked Incidents**	**June 2020 Update:** Four incidents reported to StEIS April – June (17th) 2020	**Last Review Date** June 2020	**Next Review Date** September 2020

Board Assurance Framework (BAF) Report

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO2 -** Deliver services that meet NHS constitutional and regulatory standards			**Risk Description** (***What could prevent the objective from being achieved)***	***If the Trust cannot achieve its key performance targets it may lead ot loss of services***
DATIX CODE	**2095**	**RISK ID:**	**2**		**Cause:** • Failure to deliver NHS Constitutional Targets • Failure to deliver the quality aspects of contracts for the commissioners • Patients experience indicators show a decline in quality • CQC rating of 'Requires Improvement'
Assurance Committee	Finance, Performance & Investment Committee				**Potential Effect:** • Poor patient outcome and standards of care • Inaccurate or inappropriate media coverage or reputational damage • Duplication of services with negative impact on CIP
Executive Director	Chief Operating Officer				**Potential Impact:** • Potential breach of provider license • Potential loss of reputation • Financial penalties may be applied • Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services
Risk Appetite:	**OPEN**				

Risk Rating Tracker	Risk updated April 2020 and remains extreme	**Risk Scores:**	**Initial/Raw**	**16 4x4 (L x C)**	**Current**	**16 4x4 (L x C)**	**Target**	**12 3x4 (L x C)**

Controls	Gaps in Controls	Remedial Actions
Develop a systematic Quality Improvement (QI) Methodology to ensure any service improvement can be sustained and embedded Regulatory information provided to staff in update sessions.	The workforce of the Trust does not have the sufficient level of expertise to ensure QI methodology can be applied	**June 2020:** Trust was planning to work alongside AQUA to strengthen the QI strategy (May 2020) however COVID impacted on progress. The COO and DoN are reinitiating this work with a view that from August 2020 AQUA will be on-site and supporting the further development and enhancement of the QI strategy.
Develop an Integrated Performance Report that allows the Trust to measure improvement and understand variation	The current IPR format does not adopt Statistical Process Charts as its measurement of KPIs and therefore is not taking on best practice set by regulatory bodies.	**June 2020:** The new Trust-wide IPR is now in place and the CBUs are now developing local IPRs that will be used to review performance through the Single Accountability Framework (SAF)
Adopt CBU Performance Review Boards to ensure the required scrutiny, constructive challenge and support is put into place to support delivery and improvement of the constitutional standards	The COVID-19 outbreak has meant that PRBs has been suspended for April 2020	**June 2020:** The Trust has introduced a Single Accountability Framework which will go live from June 2020. This includes the adoption of the Performance, Improvement, Delivery and Assurance (PIDA) Board for CBUs.
An integrated approach to Service Improvement against the constitutional standards between corporate, operational and governance teams.	There was no dedicated space to discuss and develop improvement plans to drive performance across the Trust	**Ongoing:** The COO has developed the Operational Performances & Improvement Group (OPIG) which brings clinical, operational and corporate functions together to support the improvement plans developed. The group holds the improvement projects to account and the forum offers an opportunity for improvement leads to offer assurance (recognise success) and formally raise concerns. This is now in place
Quality Impact Assessments for all service changes and CIPs that could adversely affect delivery of the constitutional standards	The Trust needs to develop an improved understanding in risk management / appetite to help support performance improvement and sustainability of clinical services.	**Ongoing**: The CEO now chairs the Risk & Compliance Group to ensure risk management processes and governance are robust and effective (from April 2020)
Development of Professional Standards	A lack of understanding of what best practice looks like and adopting these approaches as the "Southport & Ormskirk" way	**Ongoing:** The Trust has engaged in a number of region / nation-wide improvement collaborative across Cancer, UEC and Elective programmes. This has helped ensure the improvement projects adopt best practice and that networks are developed for the Trust to learn from other providers and recognised experts. The Trust has adopted standards / KPIs (e.g. golden patient) to ensure local approaches are in line with recognised best practice. Through PIDA Boards and OPIB the COO monitors delivery of any professional standard adopted at the Trust.
Receiving assurance from the Regulator	The Trust did not have regular formal forums for the constitutional standards to be reviewed by the regulator	**Ongoing:** The COO now meets with NHS England monthly to assess specifically the constitutional standards. The COO also ensures a formal paper is presented at the SOIB to offer assurance to the regulator and CCGs on performance & delivery. Equally the Trust submits all national SITREPS.

Ensuring the Constitutional standards are assessed, understood and reviewed at Committees' to offer the necessary assurance and / or escalation		**Ongoing:** The IPR is presented at all committees and reported through formally to Public Trust Board. In addition – the FP&I receive a quarterly report on progress against each key constitutional standard to offer assurance in actions being taken to maintain and / or improve performance
Trust policies and procedures updated in line with SITREP requirements / guidance against the constitutional standards	The Trust does not have a Head of Performance role that would offer the internal assurance that the Trust complies to SITREP guidance against constitutional standards	**Ongoing:** The Trust is now recruiting to a Band 7 Head of Performance post and has also appointed this year a Directorate Manger role that is solely responsible for Access. This provides greater strengthen in governance and compliance.
Ensure the Constitutional standard are assessed, understood and reviewed at within the Trusts Internal Governance to ensure system and processes are in place to provide transparency and accountability in delivery		**Ongoing:** The Trust continues to engage MIAA to review validation arrangements for constitutional standards and has developed SOPS for every validation process in place that are signed off by the COO.
Assurance	**Gaps in Assurance**	**Remedial Actions**
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
Constitutional Standard: Accident & Emergency - 4 hour compliance	Not delivering the 95% standard of all patients presenting to ED being seen, treated and discharged / transferred within 4 hours. The is primarily down to rising demand at the front door and poor whole system patient flow at discharge	The Trust has a specific improvement plan to focus on improvement reported through to OPIG The Trust is actively engaged in looking to identify whole system solutions to reconfigure urgent & Emergency Care pathways
Constitutional Standard: Diagnostic Waits	During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard	The Trust is now undertaking a review of the recovery phase post COVID-19 outbreak to commence routine activity from 1st June subject to NHS England guidance
Constitutional Standard: 62 day GP referral to treatment (and associated Cancer Standard measures)	Not consistently delivering the national standard due to workforce challenges across a number of tumour groups in particular Haematology and Head & Neck services	The Trust has formally set out strategic intentions to collaborate with local health economy partners to support clinical sustainability of services for the local population
Constitutional Standard: 18 week RTT	During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard	The Trust is now undertaking a review of the recovery phase post COVID-19 outbreak to commence routine activity from 1st June subject to NHS England guidance
The Trust has engaged audit and regulatory bodies to appraise / review process, policies and protocols in measurement & validation of the constitutional standards. Any recommendations are reviewed and acted upon		
Independent / semi-independent		
Southport & Ormskirk Improvement Board meets monthly CCG Pre Consultation Business Case, approved by CCG Committees in Common		

BAF Summary Report June 2020

Current and most significant risk: Impact of COVID-19 outbreak

Despite the easing of lockdown measures over the past number of weeks there does not appear to be a second surge to date. The Trust continues to see plateauing numbers of covid positive inpatients at Southport Divisional General Hospital with fewer numbers of positive patients in Critical Care on a week by week basis. The NHS remains in Level 4 national incident status with the Trust continuing in command and control mode with the Cheshire & Mersey Hospital Cell. The Cell has requested for acute Trusts to submit capital bids to support restoration planning. The Trust has submitted bids which include 3 high impact actions that support operational performance and overall clinical sustainability. National guidance around swabbing of patients prior to elective surgery was received with the requirement for 14 days isolation prior to the TCI date. This has already shown to be an issue with patients refusing to isolate due to social and economic factors. Current guidance is that patients who refuse due to covid fears or failure to isolate must remain on Waiting Lists thus increasing chance of 52 week breaches. There is a monthly paper that is FP&I receive to show the cumulative detrimental impact of the pandemic on operational performance. The paper informs the Committee of the next steps being taken by the Trust in planning and enabling Business with Covid to help maintain some parts of the elective programme and ensure the Trust can manage its urgent & emergency services.

Number of linked Risks	1987-Haematology/Oncology service 1688-Anaesthetic staffing 2056 – Missing Patient appointments/admissions	**Number of linked Incidents**	6 (issues with Outpatient appointments)	**Last Review Date**	**Next Review Date**
				June 2020	August 2020

Board Assurance Framework (BAF) Report

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO3** - Efficiently and productively provide care within agreed financial limits			**Risk Description** (***What could prevent the objective from being achieved)***	***If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.***
DATIX CODE	**2096**	**RISK ID:**	**3**		**Cause:** • Being able to deliver the required levels of CIP. • Being able to control agency costs. • Ability to service outstanding historic debt (this will be resolved in September 2020 when debt is converted to PDC) • Being able to agree sufficient income to support cost base
Assurance Committee	Finance, Performance & Investment Committee				**Potential Effect:** • Misses its control total • Additional CIPs may need to be identified and delivered. • Lack of financial stability • Inability to invest in services and new technologies • Continued borrowing to meet operational expenses resulting in significant debt
Executive Director	Director of Finance				**Potential Impact:** • No non-recurrent funding (PSF/FRF) • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention. • External interventions and financial special measures.
Risk Appetite:	**OPEN**				

Risk Rating Tracker	• Risk updated June 2020 and remains extreme. • Due to COVID-19 a new financial framework results in a break-even position for months April 2020-July 2020 with the prospect of this being extended for the remainder of the financial year. Further NHSE/I guidance is imminent. Despite this unique arrangement in 2020/21 the risk remains extreme due to the Trust's financial performance which is not currently reducing the underlying deficit.	**Risk Scores:**	**Initial/Raw**	**16 4x4 (L x C)**	**Current**	**16 4x4 (L x C)**	**Target**	**12 3x4 (L x C)**

Controls	**Gaps in Controls**	**Remedial Actions**
Control Total • Financial model produced giving early indication of issues • Annual Financial Plan to reduce underlying deficit in line with yearly target as determined by NHSE/I.	• Future Clinical Model not finalised with further potential uncertainty emerging in the aftermath of COVID-19. • Currently no Financial Recovery Plan that delivers break-even • Modelling of Acute Sustainability into 5 year LTFM to provide savings from any reconfiguration in line with Sefton Transformation Board Strategy	Action 1 - Delivered control total in 2019/20; Delivered break-even in April-July 2020; Deliver financial target set by NHSE/I for remainder of 2020/21 (not yet confirmed). **April 2020 Update:** • Trust delivered revised target set by NHSE/I - £3.6m adverse variance against the planned Control Total. • Future Clinical model to be finalised as part of Acute Sustainability work. **June 2020 update:** • April and May 2020 break-even achieved with total expenditure well within NHSE/I determined financial plan. • Acute sustainability work continuing led by joint PMO (Sefton CCG's and the Trust).
Use of Resources • Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger	• 5 Year long term financial model (LTFM) to be updated to reflect current financial performance and future financial plan. • Due to COVID-19 there is uncertainty regarding the Trust's income. The temporary arrangement for 2020/21 will eventually come to an end but there is no clarity on the future of the Payment by Results (PbR) tariff.	Action 2 - Achieve NHSI Use of Resources Risk Rating – 3 **April 2020 Update:** The Trust received an Inadequate rating in the Nov 19 CQC Inspection for UoR. A report was presented at April FP&I Committee and May Trust Board. **June 2020**: A further update on progress will be presented at the July F,P & I committee and then the following Board.
CIP • CIP Programme paused following instruction from NHSE/I due to COVID-19. The following represents "business as usual" CIP arrangements:	2019/20 CIP did not deliver.; the full year effect shortfall had an even bigger impact on the underlying financial position	Action 3 – Deliver a CIP in 2020/21 enabling the Trust to achieve the financial trajectory set by NHSE/I. **June 2020**: The Trust currently has plans of £3.9 million for delivery in

• Early and continuing dialogue with NHSE/I • Fortnightly CIP review meetings • Revised CIP planning processes and PMO co-ordination of planning and delivery • PMO Governance improved with roles and responsibilities CIP lead appointed	2020/21 CIP plan not established before commencement of new financial year.	2020/21. Further schemes required in order to reduce the underlying deficit.
Agency Spend • Weekly reporting to NHSE/I • Agency spend reviewed by Efficiency Programme Group (EPG) • People Activity Group (PAG) • eRostering	• Agency costs exceeded the NHSI cap in 2019/20 and remain high. • Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate. • Ability to attract and retain staff, reducing the vacancy rate, is not yet at a rate which will materially reduce agency spend.	Action 4 - Manage Agency Spend vis a vis NHSI cap **April 2020:** • The Trust breached the NHSE/I Agency cap of £4.891m in Sept 19 • Outturn £13.1m against a plan of £7.6m. **June 2020:** • Agency spend remains high in the first two months of 2020/21.
• Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's • Monthly governance meeting and performance meetings with Execs • Monthly Directorate Meetings (budget scrutiny at this level)	• Temporary suspension of meetings during COVID-19 (April-June)	**June 2020:** • Reintroduce meetings as part of Phase 2 COVID •
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance		
2020/21 Financial Plan as set by NHSE/I	Temporary solution is to break-even due to impact of COVID-19. Current break-even position does not provide any assurance regarding the Trust's underlying financial performance.	**June 2020:** Continue to work on CIP programme.
Future Generations Clinical Strategy and Business Plan	No clinically and financially sustainable model	**April 2020**: Acute sustainability programme is currently on hold
Sustainability Plan	Having a financially sustainable plan to achieve financial balance by 2023/24	**April 2020:** NHSE/I advised Trust financial improvement trajectories for the next four years and financial balance will be achieved with financial recovery funding. **June 2020**: Above arrangement "on hold" due to financial framework in place due to COVID-19.
Budget holder training manual and attendance records		**April 2020:** Introduced Budget holder training. Work is underway to ensure that staff that didn't attend training in 19/20 attend 2020
13 week rolling cash flow forecast agreed by NHSE/I		**April 2020:** Revenue loans will not be required from 2020/21. **June 2020**: Currently no cash concerns due to COVID-19 financial arrangements.
Reports and metrics monitored at Assurance Committees and/or Board		
• Financial Performance Reports (monthly to FP&I and BoD) • Long term financial projections • CIP achievement reports (monthly to FP&I and BoD) • Integrated Performance Reports (Board and all committees) • Fortnightly Acute Sustainability Programme Board • Monthly Performance Review Boards • Executive Team Meeting Weekly Update • CIP Reviews through fortnightly Efficiency Programme Group Meetings • Internal and External audit reports and opinion at Audit Committee		
Independent / semi-independent		
Southport & Ormskirk Improvement Board meets monthly CCG Pre Consultation Business Case, approved by CCG Committees in Common		

Northern Clinical Senate Report recommendations					
Monthly reports to NHSI with feedback					
Internal Audit • Annual Plan • reviews of budgetary controls					
External audit opinion					
Number of linked Risks	1942: Eradicating Trust deficit by 2023/24 2072: Failure to achieve 2019/20 financial control total 1688: Anaesthetic staffing	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2020	**Next Review Date** September 2020

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO4** - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated			**Risk Description** ***(What could prevent the objective from being achieved)***	***If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience*** **Cause:** • Trust level USP and associated clinical models encompassing the Trust/Community workforce needs full development and Board sign off in order to develop a supporting workforce strategy encompassing new roles and ways of working • No definitive attraction strategy for the geographic location Trust and potential partners • Lack of defined Engagement & Communication strategy owned across the Trust to target performance and delivery issues • The Trust requires the resources to build an integrated social media presence allowing it to widen its appeal to potential job applicants • Lack of Appraisal and Talent Management strategy has stunted the Trusts ability to develop the workforce. **Potential Effect:** • Difficult to develop an innovative Workforce Strategy without understanding the full range of services to be offered by Trust as this impacts on the development of new roles. • Low levels of staff involvement and engagement in the Trust's agenda. • Higher than average vacancy rates. • Failure to deliver required activity levels / poor staff productivity • Higher than average sickness rates • Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of medical staff with the capability and capacity to deliver the best care • Insufficient junior medical staffing numbers to ensure patient safety and workforce wellbeing. • A failure to successfully promote the benefits of appraisal/PDR and accountability has led to dissatisfaction amongst staff **Potential Impact:** • Poor patient experience and outcomes. • Increased costs through utilisation of higher cost temporary staffing to provide services impacting budget available to spend on direct care • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation • Reduced ability to deliver high quality service • Poor response to NHS Staff Survey • Poor levels of engagement. • Higher vacancy and attrition rates.
DATIX CODE	**2097**	**RISK ID:**	**4**		
Assurance Committee	Workforce Committee				
Executive Director	Director of Human Resources & Organisational Development				
Risk Appetite:	**OPEN**				

Risk Rating Tracker	Risk updated June 2020 and remains high (12)	**Risk Scores:**	**Initial/Raw**	**12** **3x4** **(L x C)**	**Current**	**12** **3x4** **(L x C)**	**Target**	**8** **2x4** **(L x C)**

Controls	**Gaps in Controls**	**Remedial Actions**
Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. Annually agreed funding contract with HEE	Lack of junior doctor workforce available. Regional Training Programme Directors manage the junior doctor rotation programme and do not highlight shortages and rota gaps.	**June update** – • During 2020/21 the Trust will develop and enhance clinical & nursing roles to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANPs, Consultant Nurses, ER Practitioners. Action will be ongoing for next 6 months. • Full medical establishment review to be completed in 2020 with proactive planning for gaps in doctors in training workforce. • Establish a process to get early notification of shortages in the junior doctor rotation programme from the Lead Employer. • Annual schedule of monitoring of junior doctor rotas to be implement Q3 2020 • During 2019/20 the Director of Medical Education (DME) will ensure training requirements are met and will report to the Trust Medical Director and externally to HEE

a) Workforce and OD Strategy b) Equalities Strategy c) Clinical Workforce Plan d) Recruitment & Retention Strategy (Linked to Trust and NHSI Nursing Retention Programme) e) Overseas Recruitment Campaign for Nurses f) Trust Values & Behaviours Framework g) Communication and Engagement Strategy and Plan h) Coaching Strategy i) Corporate staff Induction	a) Workforce and OD Strategy does not yet reflect NHS People Plan b) Lack of formal ED&I networks in the Trust. c) Delay in new clinical operating model. d) Lack of financial data and workforce narrative to properly plan for future workforce requirements due to lack of management engagement across the Trust. e) Possible delays due to host countries not releasing staff due to Covid. f) Relaunch of Trust Values and Behaviour Framework, delayed due to Covid. g) Strategy need to be comprehensively reviewed to ensure it is meaningful and easily translated into action. h) In-house offer delayed due to Covid. i) Needs to be linked to Values and Behaviours Framework.	a) **June Update** - Workforce and OD Strategy being reviewed in line with the interim People Plan. Final People Plan is delayed due to Covid. b) **June Update** - Actively working with Regional and National Networks to share learning and ideas. Trust Network launch in first week of July 2020. c) **June Update** – Board decisions awaited. Draft Strategy being developed whilst awaiting final decision. d) **June Update** – Draft strategy developed which is out for consultation with clinical colleagues for data, narration and accuracy checking. e) **June Update** – Campaign commenced – 3 staff offered posts with a view to September start. f) **June Update** – Post Covid a scoping exercise will be undertaken in July to determine how best to implement the Trust Values and Behaviour Framework. Branding work ongoing. g) **June Update** – Strategy to be reviewed - July 2020 h) **June Update** – In-house Coaching offer now been launched - June 2020. i) **June Update** - Corporate Staff Induction has been reviewed and values based programmes were due to launch April 2020. During Covid 19 – the OD Team has developed a fast track process including welcome pack. The OD Team phone new starters once in post as a support follow up; they will commence pre-starter phone calls April 2020. Corporate Induction will re-commence post Covid 19 and be values based.
Effective electronic rota management system gap.	Rota management system not fully utilised across the Trust	**June Update** • MIAA undertook an eRostering review which advised of limited assurance. An action plan was developed in April and will be monitored at Workforce Committee. • Work ongoing to deliver NHSI levels of attainment in 2020/21.
Mandatory training	Some subjects not meeting 85% Trust target	**June Update** • Extreme Risk identified for role specific training. Clinical Competency Working Group established to identify the Top 10 topics to be addressed first. This cuts across Medical Director, Director of Nursing and HR Director portfolio and work ongoing to ensure appropriate action and solution is found. • Core mandatory training remains above the Trust target of 85% all training taken online.
PDR process and training	Failure to meet 85% target	**June Update** - PDR process & policy in place. New At our Best leadership programme covers importance of PDR as a form of staff engagement. OD advertised PDR training sessions – both training programmes on hold during Covid 19 period – both will be re-instated in July 2020. This is being considered as a deep dive at Workforce Committee.
Leading Healthy Workplaces training	Releasing staff to attend	**June Update** – was due to launch April 2020 – however this was postponed and will need to be rescheduled post Covid.
Leadership Development Training Programme	Requirement for further development of middle managers. Release to attend the training.	**June Update** – 2 x cohorts of "At our Best" leadership programme commenced Feb and March 2020. Programmes postponed due to Covid. Further dates to be agreed.
Supporting attendance policy		**June Update** – Trust Supporting attendance policy has been reviewed and ratified. Awareness on it needs to be raised. MIAA audit – to be reviewed

Assurance	Gaps in Assurance	Remedial Actions
Management assurance		
IPR monitoring at WFC and Board. Deep Dive consideration at WFC.	Sickness absence above target but improved to 4.8%	**June Update** - Continued working with the NHSI Health and Wellbeing (reducing sickness absence rate) for 20/21.
IPR monitoring at WFC and Board. Key project in Workforce Improvement Group work plan.	Appraisal Rates below target	**June Update** - Training and Development Strategic Workstream to be developed for 20/21 of which appraisal compliance and quality will be a focus
Time to Hire monitoring and reporting.	Time to hire is longer than 30 day target (however better than regional and national median)	**June Update** - Ongoing monitoring and review of time to hire process with month on month reduction being achieved. Identification of potential causes of delay. Reports to Workforce committee.
PDR compliance and training attendance monitored	Low compliance rates for PDR	**June Update** - PDR Action planning with CBU's by October 2020
Staff Survey & Quarterly Staff FFT/Survey	Staff Survey results increasing positive scores but remain below national average in some areas	**June Update** - June 2020 Teams are reviewing the detailed analysis and action plan by and are incorporating the issues into the updated OD plan Work is on-going to consider procurement of a partner in line with recent national letter. Internally the team are looking to increase staff completion and overall staff engagement via the Big Brews approach / work with HR&CBU's to support staff engagement activities at local level
Reports and metrics monitored at Assurance Committees and/or Board • Exception reporting data • FTSUG reports • Absence Data • Turnover Data • Vacancy Rate • National Medical Revalidation process ensuring competent doctors • Quality Visits by NEDs and EDs • Workforce Committee data/IPR • Nursing temporary staffing fill rate/ NHSP contract performance		
Independent / semi-independent		
• GMC Revalidation process. • HEN visit – regular • GMC Medical Staff survey – annual		

Number of linked Risks	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2020	**Next Review Date** August 2020

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO5** - Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Risk Description** (***What could prevent the objective from being achieved)***	***If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted***
DATIX Code:	**2099**		
Assurance Committee	Workforce Committee		
Executive Director	Director of Human Resources & Organisational Development (other Executives)		
Risk Appetite:	**OPEN**		

Cause

- Values and Behaviours for our leaders are not yet clearly defined on a practical level.
- No clear definition of what talent management looks like at Southport and Ormskirk NHS Trust
- Board approved leadership and staff engagement strategies not owned across the organisation.
- Reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust.
- Senior leadership turnover has had some impact on the Trust ability to achieve good on the CQC Well Led Review
- Less than optimal management practice in some areas of the Trust have led to which has impacted the effective delivery of the vision.

Potential Effect

- Low staff morale
- Poor outcomes & experience for large numbers of patients
- Less effective teamwork
- High levels of staff absence, sickness and mental health
- High staff turnover

Potential Impact

- Poor quality of patient service
- Poor recruitment and retention of staff
- Negative impact on quality of patient care
- Potential for regulatory action and reputational damage
- Damage to the aim of becoming an employer of choice

Risk Rating Tracker	Risk remains high.	**Risk Scores:**	**Initial/Raw**	**12** **3x4** **(L x C)**	**Current**	**12** **3x4** **(L x C)**	**Target**	**8** **2x4** **(L x C)**

Controls	Gaps in Controls	Remedial Actions
Workforce and OD Strategy in place and scheduled for updating when final version of the NHS People Plan is available Underpinning strategies are: • Leadership • Coaching • Staff Engagement	Need agreed working forum to develop the final version- needs to be reflective of a whole Trust approach and have strong links to Trust operational objectives	**June Update** – • Leadership and development activity to be relaunched once business as usual returns. In the interim, coaching modules have been launched across the Trust. These are free for staff to access. • The OD Team are scoping external programmes such as the Affina OD programme (Professor West) to consider if such an approach would strengthen the work on values and behaviour.
Appraisals - policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff	Succession Planning – not fully in place Talent management - no capacity to deliver TM approaches with effective outcomes	**June Update** - A review of what Appraisal means to the organisation is to be undertaken in order to effectively redesign a process that meets Trust needs.
Mandatory training programme in place	Some subjects not at Trust target 85%	**June Update** - This forms part of an extreme risk. It has been agreed that cross directorate working at Executive level will review priorities, responsibilities, lines of funding and staff resourcing and facilities required for delivery. The first session is to be held 26 June 2020 Establish a clinical competence working group to review Top 10 risks of core mandatory & role specific training
Staff engagement strategy in place	Staff Survey Responses below national average	**June Update** - Teams are reviewing the detailed analysis and action plan by and are incorporating the issues into the updated OD plan.
Staff engagement programme	Senior leader engagement	**June Update** - The Trust delivers a staff engagement programme called The Big Brew facilitated by the OD Team to engage the workforce each year. CEO agreed to support staff engagement activities. This paused during Covid but we have examples of it being held via MS Teams and back up by socially distanced drop in's.
Annual Staff Survey	Staff engagement	**June Update** - Work is on-going to consider procurement of a partner in line with recent national letter. Internally the team are looking to increase staff completion and overall staff engagement via the Big Brews approach / work with HR&CBU's to support staff engagement activities at local level
Board Development Sessions planned throughout the year	Lack of regular Board Development sessions	**June Update** - Board session due July 2020

Controls	Gaps in Controls	Remedial Actions
Leading Healthy Workplaces training	Releasing staff to attend as Phase 2 planning for Covid has limited our availability to release staff	**June Update** - A review of on-going support and the associated training needs is a work in progress, captured form staff feedback during both phases. An offer for all staff will be scoped.
Board visibility	Insufficient visibility of Executive Team and Non-Executive Directors	**June Update** - All Board members have been actively involved in leading Covid 19 related committees, working groups, making calls to staff shielding and supporting staff in facilities. During 2020/2021 the Executive Team and Non-Executive Directors will participate in quality visits/walkabouts
Monthly and quarterly monitoring of workforce performance	Lack of resource to provide business and artificial intelligence to provide insightful workforce information	**June Update** - Collaboration with external provider to utilise BI and AI to produce insightful workforce information draft dashboard to be available for review January 2020. Investment in Workforce Information team in order to ensure organisational capability to continue production of insightful workforce information.
Deep dive reports to Committee investigating specific issues when required		**June Update** - Workforce Committee have discussed and agreed top 3 priorities
Assurance	**Gaps in Assurance**	**Remedial Actions**
Reports and Metrics monitored at monthly Assurance Committees and/or Board		
National Staff surrey (annual)	Staff Survey Engagement score not significantly improved in year	**June Update** - Staff engagement approach adopted – The Big Brew. Staff survey and staff FFT promoted via the Big Brews
Monthly KPIs for controls	Lack of resource to provide business and artificial intelligence to provide insightful workforce information	**June Update** - Collaboration with external provider to utilise BI and AI to produce insightful workforce information draft dashboard to be available for review January 2020. Investment in Workforce Information team in order to ensure organisational capability to continue production of insightful workforce information.
• Performance Reports (monthly) • Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board • Quarterly Speak up Guardian Reports • Report from Guardian of Safe Working – Quarterly to Board • Workforce Improvement Board (WIB) • Mandatory training data		
PDR training on-going	PDR compliance currently below target	**June Update** - Appraisal Task & Finish Group has been set up
Absence data	Sickness absence above target but reducing	**June Update** - The Trust will continually monitor sickness absence on a monthly basis during 2020/21
Turnover data	Deteriorating Trust position	Attrition, Attraction and Retention Strategic Workstream to commence 2020/21
Staff Engagement Scores		Staff FFT and Pulse Check results reported quarterly

Number of linked Risks	None	Number of linked Incidents	None	Last Review Date	Next Review Date
				June 2020	August 2020

Board Assurance Framework (BAF) Report

Southport and Ormskirk Hospital NHS Trust

Strategic Objective	**SO6 -** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire			**Risk Description** (***What could prevent the objective from being achieved)***	**There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services** 6a) By October 2019 develop a robust partnering strategy to enable development of a range of clinical and non-clinical joint working opportunities. 6b) By October 2019 develop a blueprint and roadmap for the acute sustainability programme				
DATIX CODE	**tbc**	**RISK ID:**	**6**						
Assurance Committee	**Strategy Task and Finish Group and Trust Board**								
Executive Director	Deputy CEO/Director of Strategy								
Risk Appetite:	**HUNGRY**								
Risk Rating Tracker	Risk reviewed June 2020 and remains extreme			**Risk Scores:**	**Initial/Raw**	15 3x5 (L x C)	**Current**	15 3x5 (L x C)	**Target**	9 3x3 (L x C)

Controls	**Gaps in Controls**	**Remedial Actions**
Robust system governance in place, including: ▪ Southport, Formby & West Lancs Acute Sustainability Programme Board ▪ Cheshire & Mersey Health & Care Partnership: Strategic Oversight Group ▪ Provider Alliance ▪ SOIB - leading Vision 2020	Financial constraints for delivery of facilities improvements	Develop, implement and deliver the agreed organisational transformational CIP Schemes. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to HOIB. **June 2020 update:** structures within Sefton Place are under review and it is likely that the Acute Sustainability Programme will report directly to the Health and Wellbeing Board. The CMHP has revised its programme and the Trust work will no longer feature we are yet to understand how this ill impact.
Robust internal governance in place, including: ▪ Strategy Task and Finish Group ▪ HIB - leading Vision 2020 and Single Improvement Plan	Delay in delivering Transformational CIP Schemes	Recruitment to substantive positions to reduce agency spend. **June 2020** update: Operational planning has been put on hold in the light of Covid-19 however work on resolving the workforce situation continues with key executives tasked with developing a clinical workforce strategy.
Documentation in place; ▪ S&O Operational Plan 2019/20 ▪ STP 5 year plan complete and part of C+M STP plan	Whole system engagement - support from key health and social care partners to address increased demand on the non-elective pathway and helping reduce LoS for patients not requiring acute hospital care	Action 1 - Establish a Strategic Task and Finish group with executive and non-executive membership to provide assurance to the Trust Board on the robustness of the development and delivery of the Acute Sustainability Programme. To commence in June 2019 and meet monthly. June 2020 update:The Task and Finish Group has continued to meet and has helped shaped discussions ahead of Board. The whole Board has not agreed a sustainability statement and this will now be worked up into a route map to ensure progress and pace are maintained.
	Operational plan in development	Action 2 - Report progress on the delivery of the Operational Plan using the Single Improvement Plan. On-going reporting of progress monthly internally to Trust Board via HIB, and externally to SOIB. June 2020 update:While the SOIB continues to meet its format has changed and the Single Improvement Plan is no longer taken. Work needs to be done to consider how the strategic programme can now be articulated within and outside the organisation.
	Communication and Engagement Strategy	Action 3 - Develop, implement, embed and review Communication and Engagement Strategy and Plan. To be produced in July 2019 and monitored by the Acute Sustainability Programme Delivery Group.

		June 2020 update:A communication and engagement plan has been in development however there has been concern about implementing it too soon. In June Trust Board were clear that pre-engagement conversations with the public are overdue and should begin urgently.
Assurance	**Gaps in Assurance**	**Remedial Actions**
Management assurance		
Internal Assurance ▪ Vision 2020 updated and agreed at Board, updated version now in development ▪ Single Improvement Plan signed off by Board and monitored through HIB and SOIB - though to be given to how this now is conducted ▪ Minutes of Monthly Contract Review Meetings		
Reports and metrics monitored at Assurance Committees and/or Board		
• Performance monitoring of patient experience and clinical outcomes • Incident Data (including SIs / Never Events) • CEO's reports to Board • Deputy CEO reports to Board • Single Improvement Plan reports to Improvement Board • Single Improvement Plan reports within IPR • Finance Reports include contractual and commissioning issues, where relevant reported to Board • Progress of agreeing contracts reported via Finance to Board • Business Cases involving commissioners reported, where these occur, reported to Board		
Independent / semi-independent		
Southport & Ormskirk Improvement Board meets monthly CCG Pre Consultation Business Case, approved by CCG Committees in Common		
Northern Clinical Senate Report recommendations		
Monthly reports to NHSI with feedback		
Internal Audit • Annual Plan • reviews of budgetary controls		
External audit opinion		

BAF Summary Report April 2020

This risk is discussed routinely at Strategy Task and Finish Group (Chair Neil Mason) and has routinely been to HMB as part of the new BAF. An outline Pre-Consultation Business Case was produced in October 19 which pointed the direction for some more focussed work. Subsequently a draft outline business case that describes the principles and application of core acute services was brought to Trust Board in June 20. The work is now being more closely supported by NHSE/I and a range of further scenarios are to be considered to deliver service sustainability. Board Strategy sessions were held in February, March and June where key key decisions were taken which set the direction for this work during the year.

Number of linked Risks	1942: Eradicating Trust deficit by 2023/24 2072: Failure to achieve 2019/20 financial control total 1688: Anaesthetic staffing	**Number of linked Incidents**	**Add:** None	**Last Review Date** June 2020	**Next Review Date** September 2020

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB110/20**	**FOI Exempt**	**NO**
Report Title	**CORPORATE RISK REGISTER**		
Executive Lead	Bridget Lees - Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant Director of Integrated Governance Katharine Martin, Senior Information Analyst / Datix Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the current extreme risks to the organisation.

Executive Summary

At the Risk and Compliance Group in June, the Group agreed the downgrade of the risk relating to Older People's Care (2173). It was considered that the progress made against the action plan meant that this could be downgraded to a high risk rated 12 (Major x Possible).

The Group also approved the addition of a new risk relating to Fragile Services (2230). This risk relates to some clinical services considered 'Fragile' due to workforce shortfalls or excessive financial cost. This risk is currently rated 16 - extreme (Major x Likely). The action plan for this risk is currently under development. Therefore three extreme risks remain on the Trust Board Risk Register.

Recommendations

The Board is asked to **receive** the risk register and support the changes to the risks which have been formally agreed at Risk & Compliance Group.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Katharine Martin, Senior Information Analyst / Datix Manager	Bridget Lees, Director of Nursing, Midwifery and Therapies

JUNE 2020 – SUMMARY OF HIGH LEVEL RISK REGISTER AS AT 25/06/2020

Risk ID	Principle Objective(s)	Risk	Executive Lead	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
1688	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Inadequate Staffing Levels in Anaesthetic Department	Chief Operating Officer	=20	15↓	=15	=15	Risk closed - new risk added to reflect position for current financial year (ID 2226)	
1902	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Failure to comply & improve governance of services in relation to the areas of non compliance identified by CQC	Director of Nursing & Quality	=16	=16	=16	Risk closed - new risk added to reflect position for current financial year (ID 2218)		
2218	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Failure to comply & improve governance of services in relation to the areas of non compliance identified by CQC	Director of Nursing & Quality	↓			!16	12↓	=12↓
1862	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Maintaining safe quality nursing care with current level of nursing & HCA vacancies	Director of Nursing & Quality	=16	=16	=16	=16	=16	=16
2161	SO3 - Efficiently and productively provide care within agreed financial limits	Failure to achieve financial control totals	Director of Finance	!16	=16	=16	=16	12↓	=12↓
2052	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Older Peoples Care	Director of Nursing & Quality	=16	=16	=16	=16	=16	12↓
2056	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards	Missing Patient appointments/admissions	Chief Operating Officer	=20	=20	=20	=20	12↓	=12
1977	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO3 - Efficiently and productively provide care within agreed financial limits SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Peadiatric Dietetics Band 6	Director of Nursing & Quality	=16	=16	=16	=16	6→	=6→
2122	SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services	Medicines Management	Executive Medical Director	=15	=15	=15	=15	12↓	=12→
2130	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff	Director of HR and OD	!16	=16	=16	=16	=16	=16
2123	SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Overdue Ophthalmology backlog	Chief Operating Officer		!20	=20	=20	10→	=10
2230	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Fragile Services	Chief Operating Officer						!16

TRUST RISK PROFILE AS AT 25/06/2020 – Following review at Risk & Compliance Group June 2020

	CONSEQUENCE (impact/severity)				
LIKELIHOOD (frequency)	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)					
Likely (4)				**1862 - Maintaining safe quality nursing care with current level of nursing & HCA vacancies** **2130 - Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff** **2230 – Fragile Services**	
Possible (3)		**1977 - Paediatric Dietetic Service Community West Lancashire**		**2218 - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC** **2122 – Medicines Management** **2226 - Inadequate Staffing Levels in Anaesthetic Department** **2056 – Missing Patient appointments/admissions** **2161 - Failure to achieve financial control totals** **2173 - Older Peoples Care**	
Unlikely (2)					**2123 - Overdue Ophthalmology backlog**
Rare (1)					

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards					Link to BAF	SO2
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
20/06/2018	1862	Director of Nursing & Quality	Claire Harrington	Maintaining safe quality nursing care with current level of nursing & HCA vacancies				
Description	If levels of Registered Nurse & HCA staffing remains below funded establishment due to vacancies then patients may experience poor quality of care (safety & patient experience).							
Controls	Safe Care monitored daily Mon-Fri and aligned to Staffing Huddles Daily staffing huddles with Matrons & Senior nurse Review Health Roster Policy & compliance ratified July 2019 NHSP contract to support flexible workforce pipeline Nursing establishments uplifted & ratified at Trust Board May 2019 Staffing data reviews through support and challenge meetings within CBU's Incident report (red flags) to identify if there has been a harm of patients due to staffing levels Incident reporting in place to identify if there has been a harm of patients due to staffing levels in accordance with NICE 'red' flags Safe staffing report to WorkForce Committee & Trust Board on a monthly basis Additional tier 2 nurse agency in place Contract block booking for RN agency to support fill rate on day shifts during winter pressured months Weekend Matron Rota commenced Jan 2020 to support safe staffing Nursing and Midwifery Recruitment and Retention Group being established. Further Nursing establishment review and roster management review underway target completion April 2020 Addition of 18 third year students in last 6 months of training given temporary contracts at Band 4, for 12 weeks Addition of 26 second and third year students will be offered temporary contracts at Band 3 for 12 weeks Ongoing focused recruitment campaigns for RN and HCA's including RN international recruitment. Task and finish group led by Head of Resourcing to produce a workforce plan for 22nd May 2020 Weekly review of temporary staffing allocation and spend with HoNs/DDoN/ Roster coordinator and ADoN (workforce)						**Gaps in Controls**	Temporary pause in the progress of international nurse recruitment. Absence of current workforce Strategy/Plan Increased sickness and risk assessed redeployment due to COVID 19 Temporary pause to trajectory of local face to face recruitment days.	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	09/06/2020	09/07/2020
Assurance	Monthly staffing report CQC inspection Quality and safety reports Complaints Incident reporting Bi annual staffing reports Workforce data (sickness & AL)						**Gaps in Assurance**	Delay in Bi-annual staffing report (commenced)	

	Dedicated H roster Lead for N&M Establishment review process SOP ratified by HMB - May 2019 Monthly E roster meetings & dashboard in place E-Roster policy QI methodology in place to support E-Roster performance Temporary staffing weekly review meetings with HoN'S DDoN'S ADoN Workforce, Resource Lead, Finance Redeployment Tool to support awareness of temporary re-assignment of staffing				
Action Plan	Senior nursing staff to be deployed to identified areas to review current nursing practice and care delivery	**Action Plan Due Date**	29/06/2018	**Action Plan Rating**	Completed
	Implement Nurse Establishment Review		27/12/2019		Completed
	Review Model hospital for S&O data		27/12/2019		Completed
	Upload new budgets Inform Ward managers/Matrons of final e roster rota Upload new templates		31/12/2020		Completed
	Post May 2019 NER recruitment campaign for RN/HCA and band 4 posts		31/12/2020		Completed
	Complete process map for nursing associate role and clarify role/responsibilities with nursing teams. Commence Recruitment to NA posts in line with establishment.		30/06/2020		Completed
	Deploy senior staff to wards identified to monitor quality of care on identified wards.		31/01/2019		Completed
	Establish quality improvement groups to address actions following CQC inspection, complaints and incidents		29/03/2019		Completed
	Complete Nurse Establishment review based on national guidance		31/05/2019		Completed
	To develop a workforce plan to manage, plan and develop our workforce		30/06/2020		Moderate Progress Made
	Carry out nursing establishment review every six months to ensure the organisation is satisfied that the nursing and midwifery staffing is set at an appropriate level to deliver safe care.		01/07/2020		Actions Almost Completed
	Establishment of a Nursing recruitment and Retention group to support Workforce Improvement Group Work stream. Implement International recruitment programme		14/07/2020		Moderate Progress Made

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
06/12/2019	2130	Director of HR	Tracy Gunn	Clinical competence of the multi-professional patient facing workforce - Nurses, Medics, AHP, Clinical Support Staff				
Description	If the Trust fails to have in place the right infrastructure and resources to deliver and monitor a comprehensive clinical skills programme for the multi-professional workforce then this will result in a breach of regulatory requirements (NMC, HEE, GMC, and CQC) and may reduce patient & staff safety, increase staff turnover & poor quality of care, and has the potential for legal action and reputational damage.							
Controls	Medical Education coordinating a collaborative approach to academic planning with a view to establishing MDT programmes of training Medical Education, Nurse Education & Practice Education Facilitation Teams in place Medical Education Strategy incorporates structured plan to move towards cohesive MDT approach to planning, delivery & quality assurance management of Clinical Skills training Staff have access to 2 x Clinical Education Centres in place Clinical skills programme offered via medical and nurse education teams Medical Education have expanded room resource to include two additional Clinical Skills zones to support training of all clinical & medical groups Clinical Competency Working Group (CCWG) established Feb 2020 Role specific training reports circulated monthly to line managers from Feb 2020 Core & role specific training reports monitored via CBU PRB's from Feb 2020 Ward Manager core mandatory training dashboards available Clinical induction programme reviewed & launched March 2020 Top 10 clinical risks identified by CCWG (March 2020) All staff have access to ESR eLearning modules to update core mandatory & some role specific training All Trust employees have access to ESR Manager & Employee Self Service (as appropriate) to review team & individual training competences & compliance dashboard Full implementation of the National Core Skills Framework (CSF) for core mandatory training subjects Induction & Core Mandatory Training Policy in place MIAA Audit (Sept 2018) reported 'substantial assurance' (Induction & Core Mandatory Training Policy) Medical Education undertake training needs analysis of target cohorts in line with GMC, HEE & Curriculum requirements Medical Education incorporate resource planning annually, aligned to academic programming, addressing equip & consumable requirements Medical Education undertook internal review, culminating in production of 2 x SOC's to provide resilience in staffing and facilities					**Gaps in Controls**	No identified Clinical Education Lead or Clinical Education Team to deliver a MDT approach to training Silo working of medical & nurse education teams (although improving) reporting to 2 Executive Leads Confusion around where responsibility for the various aspects of the HEE Contract sits - across Medical, Nursing & HR No Head of Nurse Education in place - JD awaiting final approval from AfC No TNA's for clinical skills so scale of training requirements not yet understood 2 x SOC's submitted as an interim measure to secure clinical educators and enhanced facilities - no response to date No identified budget to purchase consumables & equipment or support maintenance contracts No governance arrangements in place to review, approve or monitor role specific training / clinical skills competence Limited clinical skills facilities at both sites leads to conflicting priorities between nurse & medical education CBU ability to release staff to attend training leads to high DNA rates & regular Datixs Use of subject matter experts to deliver training causes conflict with service delivery & increases class cancellations New starters do not currently have access to mandatory eLearning modules prior to commencement date	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	05/06/2020	03/07/2020
Assurance	Non-medical clinical education group provides a AAA report to workforce committee. Medical Education Committee AAA Report Core mandatory training reported monthly via HR dashboard at Workforce Committee Core mandatory training reported monthly to Board via IPR Core mandatory & role specific training monitored via CBU Performance Review Boards (PRB) Core & role specific monthly reports circulated to Exec, senior leaders & managers across the Trust including Trust compliance, CBU compliance, subject compliance, individual compliance MIAA Audit (Sept 2018) reported 'substantial assurance' (Induction & Mandatory Training Policy)					**Gaps in Assurance**	No Board overview or scrutiny of key issues relating to the HEE contract Medical does not escalate through an AAA report only to Workforce Committee CQC highlighted gaps in assurance of medicines management and resuscitation competence No assurance currently provided through Workforce Improvement Group (WIG) Significant gaps in governance arrangements	
Action Plan	Establish a Clinical Skills Working Group (CSWG) & Terms of Reference to deliver this action plan with					**Action Plan Due Date**	28/02/2020	**Action Plan Rating**	Completed

	representation from the relevant business units - Training, Nursing, Medical, AHP & Performance teams.				
	Director of Medical Education & Head of Medical Education to re-establish the Medical Education Committee/Group as an interim measure - this will be reviewed by the group as part of an Education Governance Framework		02/03/2020		Completed
	Clinical skills training programme of Top 10 risks established for nurses, AHP's, medics, undergraduate medical & nursing students		29/04/2020		Completed
	Single point of failure as one staff member with capability to update OLM - this will delay process so TNAs will need to be placed in priority order by the CSWG		29/04/2020		Completed
	Recruitment of an interim Compliance Training Project Manager (18 months) with the expertise & capacity to deliver & expedite the delivery of the training action plan		01/07/2020		Completed
	Establish an effective reporting & monitoring process to ensure the CBU's can effectively manage and monitor mandatory & Top 10 training compliance within their areas via the PRB and Board IPR - to include each subject compliance % rate and DNA % rate per month		31/07/2020		Completed
	Review of eLearning alternatives to face to face training to improve accessibility for staff to remain compliant		31/07/2020		Completed
	Review of the current Standard Operating Procedure to deliver a governance framework / sign off process for the management of clinical skills / role specific training needs analyses (TNA's)		30/09/2020		Completed
	Create a training matrix that reflects training requirements for staff groups / training hours required / cost of training by staff group to organisation		31/12/2020		Completed
	Work with Finance to understand the alignment of the HEE Learning & Development Agreement (£6million) to effectively deliver the Clinical Education Strategy and the university/educational curricula to improve the clinical educational experience of students and trainees and the wider workforce		04/09/2020		Moderate Progress Made
	Development of a Trust Clinical Education Strategy & a full review of the supporting team structures to deliver a clinical skills training programme to meet the outcomes of the various educational curricula and organisational requirements for clinical skills training		02/07/2020		Moderate Progress Made
	A TNA of the Top 10 training risks to be completed & mapped on to OLM for monitoring & assurance		31/07/2020		Actions Almost Completed
	Establish an Education Governance Framework for the ongoing management & monitoring of the HEE contract including clinical skills training		31/07/2020		Moderate Progress Made
	Finalise the implementation of the NW streamlining project for new starters to access ESR eLearning modules prior to start date		31/07/2020		Actions Almost Completed
	Development of core mandatory and role specific training matrixes		30/09/2020		Moderate Progress Made

Strategic Objective	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire			Link to BAF	
Business Unit	Executive Management	Specialty	Trustwide	Location	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
21/05/2020	2230	Chief Operating Officer	Donna Lynch	Fragile Services

Description	There is a risk that the trusts clinical services become increasingly difficult to deliver (fragile) and that clinical outcomes are compromised due to unwarranted variation, fragmentation of services and sub-scale specialties. In this case the definition of Fragile is those clinical services provided by S&OHT which are a cause for concern due to workforce shortfalls or excessive financial cost; and are in danger of not being able to be sustained (time period to be quantified by clinical service. The main clinical services that meet this definition are Haematology, Pain, Dermatology, Older People Services (Geriatricians), Anaesthetics, Radiology, General Medicine, Head & Neck, Stroke, Community Paediatrics, Dietetic services, Ophthalmology and Acute Medicine

Controls	Gaps in Controls
The Trust has formally declared at Trust Board ongoing challenges in delivering safe and consistent clinical services mainly are attributed due to workforce pressures. This has triggered formal acknowledgement and dialogue with NHS England and other NHS providers to determine & consider next steps. Closure of referrals general elective Haematology, Pain, and Dermatology – minimise impact to patients. An over reliance in using temporary workforce solutions (i.e. agency and outsourcing) across the 14 fragile clinical services which is adversely affecting the expenditure bill of the Trust and more importantly increases the variation in clinical practice; and therefore risk in delivery of efficient, responsive and effective services. The introduction of the System Management Board / Group for Southport & Formby and West Lancashire to determine any possible system transformation between secondary and primary care to look at alternative models of care that support improving resilience and accessibility of clinical for the local population. The Trust has formally reached-out to other NHS providers to request mutual aid (e.g. Haematology and Head & Neck). Discussions are slow due to COVID-19 impact and operational / strategic pressures in other parts of the LHE system (i.e. formation of LUFT through the transaction between UHA and Royal Liverpool). Introduced targeted recruitment campaigns to support strategies to influence the market forces.	Due to the COVID the governance arrangements of the Cheshire & Mersey STP has stepped into a level 4 command and control function. The NHS has been prioritised on COVID-19 response and management. Therefore system transformation supporting ambitions of the NHS 5YFV and the C&M STP have halted and been delayed. The CEO and Chair have a meeting with NHS E in July to consider next steps and agree arrangements to move forward on the necessary actions to support the notion of the Trust not being clinically sustainable. The Trust needs agreement on the formal links with other NHS providers to commence robust clinical dialogue in achieving sustainable models for the local population. At this moment without this direction the Trust is working through ad-hoc arrangements with multiple NHS providers without any clear MOU and / or mandate. This makes engagement at all levels challenging. The COO has initiated a System Management Group with CCG leads to review local solutions against a number of the fragile services. The conversations are positive however the main risk here is that those services defined as fragile at the Trust are indeed that service lines that other local NHS providers are also experiencing some difficulties with.

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	24/06/2020	12/07/2020

Assurance	Each of the 14 clinical services has individual risk assessments (including mitigating actions) that are monitored at each CBUs Governance meetings and escalated through to the Risk & Compliance Group. The risk assessments are also reviewed at the CBU PIDA Boards which oversees the Trust Single Accountability Framework which ensures those mitigation actions are progressing and supported. The Trust is actively engaging formal support from NHS England – the solution to acute sustainability needs to be owned at STP level as it cannot be achieved through local intervention (it requires a whole system transformation) The Trust is actively in dialogue with other local NHS providers and CCG to review mutual aid and alternative models of care between current secondary and primary care providers across the local health economy	**Gaps in Assurance**	The Level 4 COVID-19 critical incident has introduced a command & control structure which reduces local autonomy in making strategic decisions for the local population. The meeting with NHS England in July will play a pivotal part in setting out the blueprint for the required action to progress across 2020/21 Many of the fragile services are indeed related to workforce pressures which are national issues however compounded greatly at the Trust due to size and workforce numbers.		
Action Plan		**Action Plan Due Date**		**Action Plan Rating**	

Alert, Advise, Assure (AAAs)
Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	22ND JUNE 2020
Lead:	JIM BIRRELL

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The committee received a CIP status report and, whilst acknowledging that there is no requirement for the Trust to deliver CIP within the first four months of 2020/21, it is disappointing that little progress has been made during this period to develop mature plans that will identify specific savings and mechanisms for delivery.
- It was reported that the Trust has 6 over-52 week waiters.

ADVISE

- A PLICS Month 11 report was received that illustrated indicative surplus/deficit positions across each clinical speciality. It was agreed that PLICS reporting was a positive step forward and that a detailed plan to roll out PLICS, alongside Service Development Plans, would be presented to FP&I in August. This will enable services to challenge the apportionment methodology that has been applied, and to refine the accuracy of PLICS.
- The Trust has reported an 800% increase in the use of telemedicine through Attend Anywhere during COVID, and opportunity to provide sustained digitalisation of some outpatient services beyond COVID could lead to operational efficiencies longer term.
- The Integrated Performance Report (IPR) was received, together with an overview of Outpatient, Elective, Urgent Care Programme and Cancer Services during COVID. The positive performance of A&E, which was ranked 8th highest nationally based upon May 2020 performance metrics, and cancer services that has been able to maintain a full and robust cancer pathway for all 2 week wait referrals, were highlighted and acknowledged.
- It was reported to FP&I Committee through the IM&T sub-Committee, the requirement for the Trust to replace MS Office 2010 by October 2020. Funding arrangements for the procurement of a replacement system are yet to be agreed.

ASSURE

- The month 2 financial position was received, which illustrated that the Trust delivered a breakeven position in month 2, and overall there is underspend against the budget due to a fall in non-COVID activity. The broader implications of this are not yet clear given uncertainties to the national funding environment.
- Plans to help ensure the Trust is prepared for winter with COVID will be brought to September's FP&I committee including specific proposals for managing the frailty pathway.
- Drug expenditure remained under control throughout 2019-20, but there is some uncertainly over the possible impact on prescribing patterns of COVID.

New Risks identified at the meeting:

None identified

Review of the Risk Register: *No action taken*

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB112/20**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Michael Lightfoot, Head of Information		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Trust's performance against key national and local priorities.

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 19/20 SOF and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator has a Statistical process Control (SPC) chart and commentary. Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

The Executive summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendations

The Board is asked to receive the Integrated Performance Report detailing Trust performance in May.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Michael Lightfoot	The Executive Management Team

Activity Summary – May 2020

Southport and Ormskirk Hospital NHS Trust

Indicator Name	May 2019	April 2020	May 2020	Trend
Overall Trust A&E attendances	10,469	4,307	6,028	↓
SDGH A&E Attendances	4,918	2,678	3,590	↓
ODGH A&E Attendances	2,420	726	983	↓
SDGH Full Admissions Actual	1,090	988	1,084	↓
Stranded Patients AVG	191	104	122	↓
Super Stranded Patients AVG	79	33	41	↓
MOFD Avg Patients Per Day	67	25	38	↓
DTOC Unconfirmed Avg Per Day	8	-	-	
GP Referrals (*Exc. 2WW*)	2,707	780	422	↓
2 Week Wait Referrals	783	379	497	↓
Elective Admissions	200	32	45	↓
Elective Patients Avg. Per Day	6	1	1	↓

Activity Summary – May 2020

Southport and Ormskirk Hospital NHS Trust

Indicator Name	May 2019	April 2020	May 2020	Trend
Elective Cancellations	26	11	18	↓
Day case Admissions	1,843	471	487	↓
Day Case Patients Avg. Per Day	59	16	16	↓
Day Case Cancellations	32	9	6	↓
Total Cancellations (EL & Day Case)	58	20	24	↓
Total Cancellations (On or after day of admission, non clinical reasons)	7	2	0	↓
Outpatients Seen	22,701	10,501	12,501	↓
Outpatients Avg. Per Day	732	350	392	↓
Outpatients Cancellations	4,074	9,207	5,969	↑
Theatre Cases	568	147	201	↓
General & Acute Beds Avg. Per Day	413	435	449	↑
Escalation Beds Avg. Per Day	19	5	0	↓
In Hospital Deaths	82	147	60	↓

NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report

Board Report

May 2020

Southport and Ormskirk Hospital NHS Trust

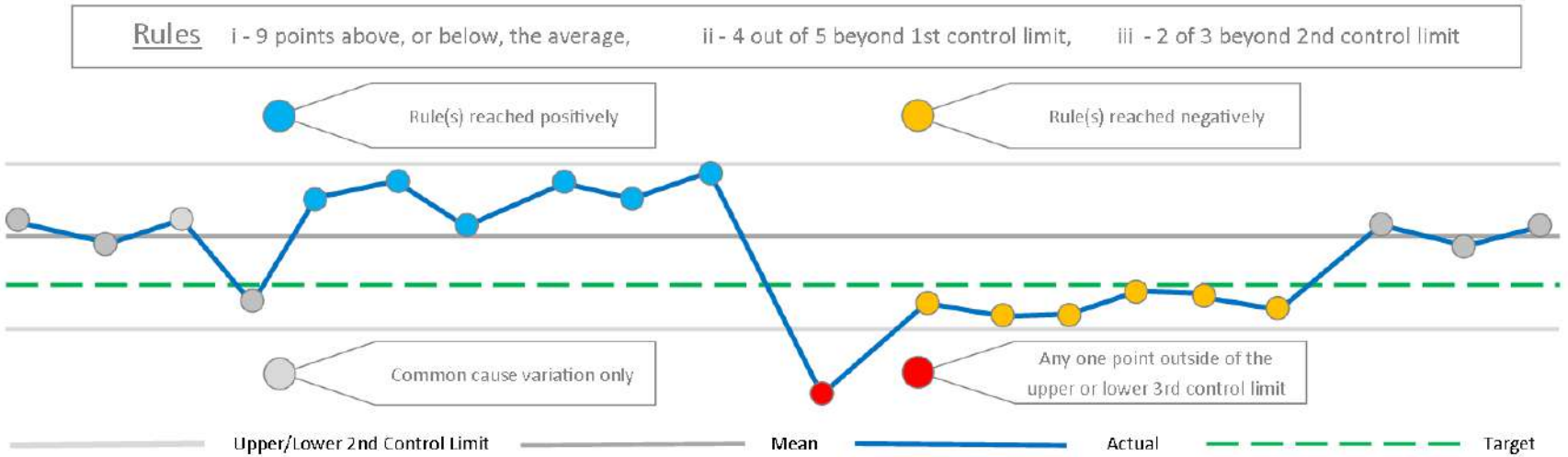
Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line (**dark grey**) is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

		Assurance			Variation		
							
Quality	Harm Free	1	0	13	5	2	7
	Infection Prevention and Control	0	0	4	1	0	3
	Maternity	1	0	7	1	0	7
	Mortality	0	0	3	0	0	3
	Patient Experience	1	0	9	1	0	9
Operations	Access	0	1	9	2	3	5
	Cancer	1	0	5	1	0	5
	Productivity	0	0	10	7	0	3
Finance	Finance	0	2	5	0	0	7
Workforce	Agency	0	0	1	0	0	1
	Organisational Development	0	0	2	1	0	1
	Sickness, Vacancy and Turnover	0	1	9	1	5	4

Assurance

Whether SPC rules triggered should cause concern or provide assurance.

	Indicates that this indicator has not changed significantly although it may be underperforming.
	Indicates that there is a level of assurance around this indicator.
	Indicates that there is some concern around the performance of this indicator.

Variation (Past 3 Months)

Whether SPC rules have been triggered positively or negatively overall for the past 3 months.

	Indicates that there is no significant variation recently for this indicator.
	Indicates that there is positive variation recently for this indicator.
	Indicates that there is negative variation recently for this indicator.

Quality

Harm Free

STEIS – I case in month pre-term birth

Nurse Staffing and CHPPD

Nurse Staffing and CHPPD. National Reporting has ceased during COVID. Care Hours Per Patient Day (CHPPD) Plan = 11.5. May 20 is reflective of areas where bed occupancy has reduced and
and also function has changed due to COVID. Specific areas are AED OBS (related to change in function in ED), Paeds Unit and EAU (related to lower occupancy). Safe Staffing metric reports 82.3% for May 20, however further adjustments have been made to the roster template. Expect May 20 figure to adjust up to 88.78% Demand templates altered for COVID will return to normal as changes were put in place for temporary period until the end of June; the increase in demand templates may skew the figures between April and June if the inflated demand has not been used. This is being cleansed retrospectively.

Pressure Ulcers – Reporting of grade 2 pressure ulcers at board level is now in place.in the IPR. A quarterly Pressure ulcer report has been added to the business cycle for Quality and Safety Committee commencing Aug 20 to review performance over
Time, themes reporting and action taken. The Director of Nursing has commissioned an external peer review to benchmark against other services commencing July 20.

Patient Safety incidents Moderate harm – 8 in month

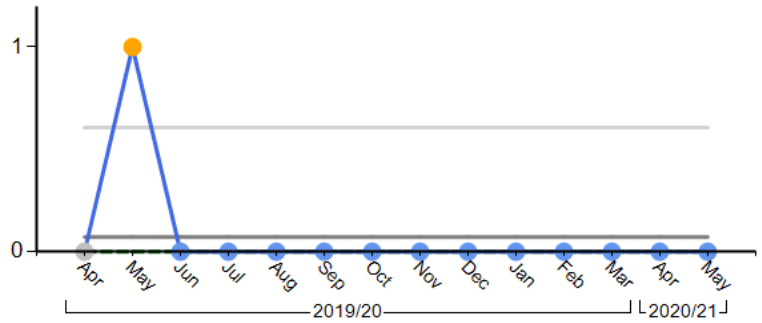
Incidents (Low, near miss, no harm) – it is noted reporting reduced over last 3 months, however reporting has now started to increase in month of June suggesting recovery. The Trust is noted to be one of the higher reporter of incidents nationally. This trend reduction will be evaluated against peers though national reporting schemes to benchmark during the last 3 month period.

Falls

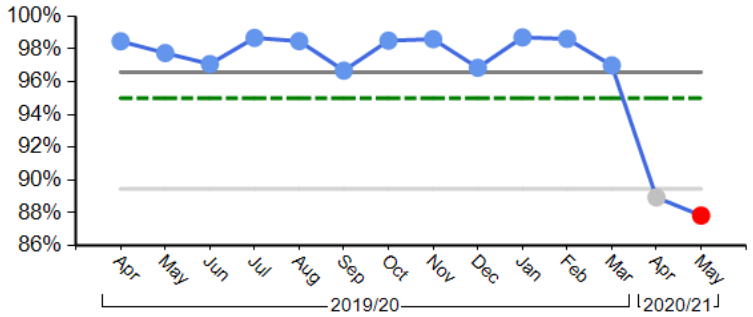
Whilst the total number of falls per 1000 bed days has increased from 3.74 to 4.85, falls resulting in harm per 1000 days has reduced to 0.09 from 0.29

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	May 20		0	0	Apr 20	0	0	
VTE Prophylaxis Assessments	95%	87.8%	314	May 20		95%	88.9%	Apr 20	95%	88.3%	
Harm Free (Safety Thermometer)	95%	97.9%	7	Mar 20		95%	99%	Feb 20	95%	98.1%	
Falls - Moderate/Severe/Death	0	1	1	May 20		0	3	Apr 20	0	4	
Patient Safety Incidents - Low, Near Miss or No Harm	822	526	526	May 20		822	396	Apr 20	822	922	
Safe Staffing	95%	90.2%	N/A	May 20		95%	80.5%	Apr 20	95%	85.3%	
Fractured Neck of Femur	90%	70.6%	12	May 20		90%	40%	Apr 20	90%	54.1%	
Hospital Pressure Ulcers - Grade 2	2	8	N/A	May 20		1	3	Apr 20	18	11	
Hospital Pressure Ulcers - Grades 3 & 4	1	3	3	May 20		1	0	Apr 20	1	3	
WHO Checklist	99.9%	100%	0	May 20		99.9%	100%	Apr 20	99.9%	100%	
Sepsis - Timely Identification	75%	100%	N/A	Mar 20		75%	100%	Feb 20		98.9%	
Sepsis - Timely Treatment	75%	70%	N/A	Mar 20		75%	70.8%	Feb 20		78.6%	
Care Hours Per Patient Day (CHPPD)	7.9	11.5	N/A	May 20		7.9	11.7	Apr 20	7.9	11.6	

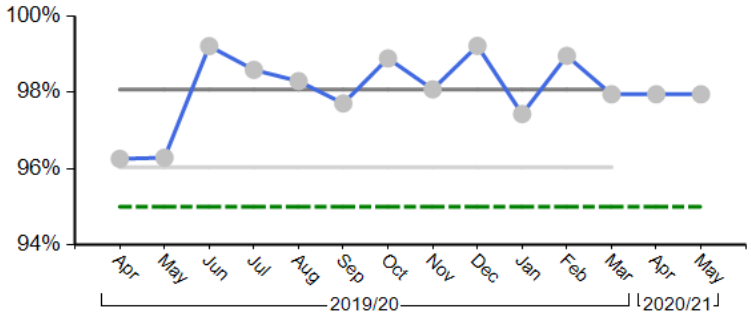
Never Events



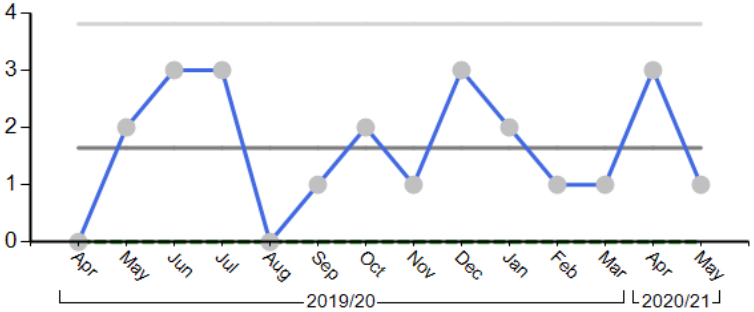
VTE Prophylaxis Assessments



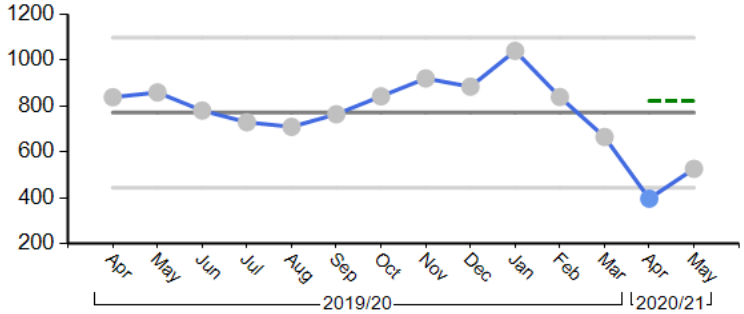
Harm Free (Safety Thermometer)



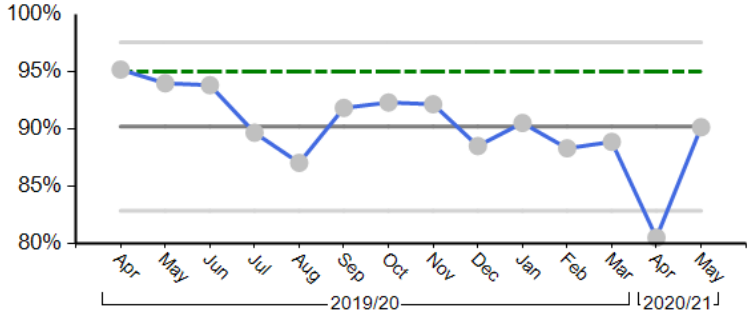
Falls - Moderate/Severe/Death



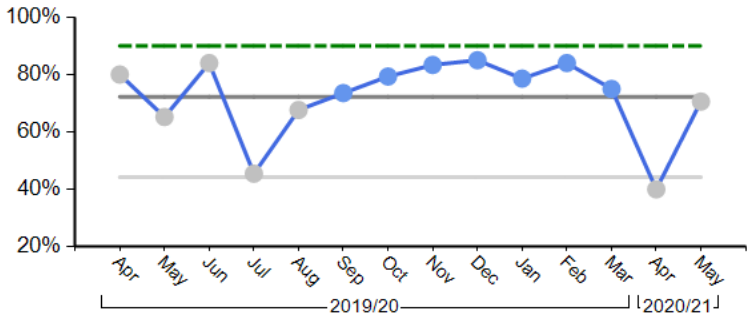
Patient Safety Incidents - Low, Near Miss or No Harm



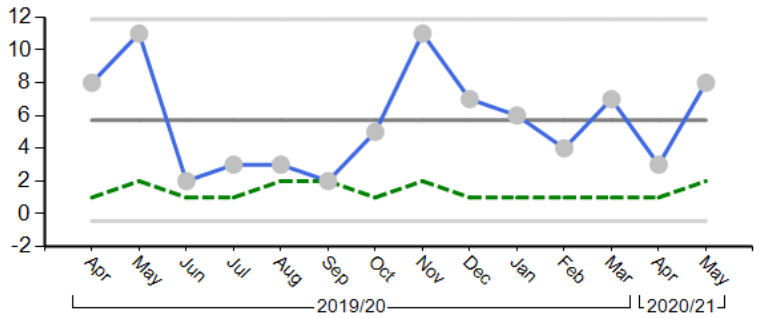
Safe Staffing



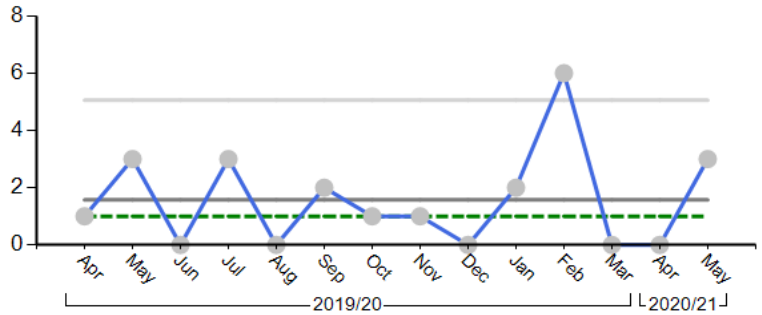
Fractured Neck of Femur



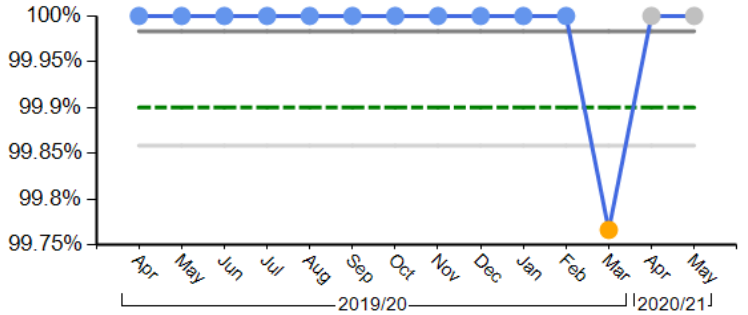
Hospital Pressure Ulcers - Grade 2



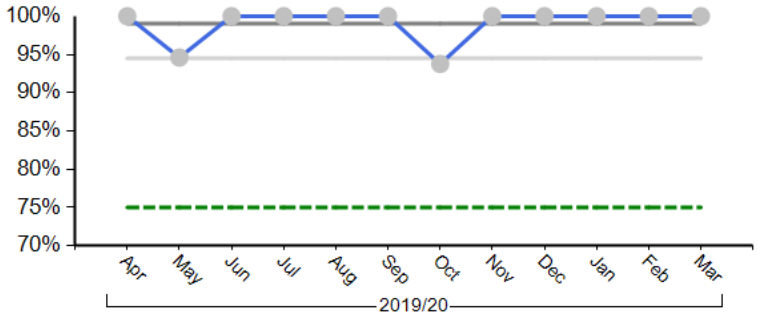
Hospital Pressure Ulcers - Grades 3 & 4



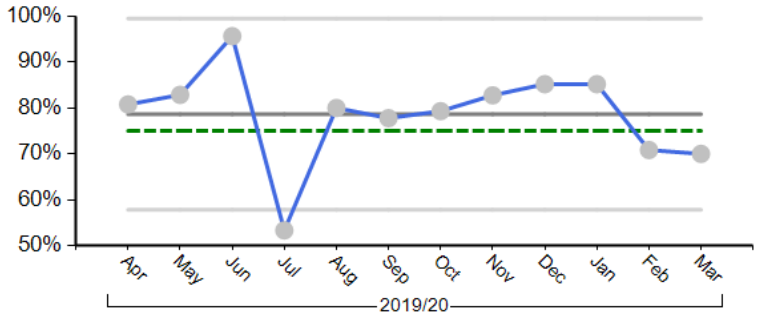
WHO Checklist

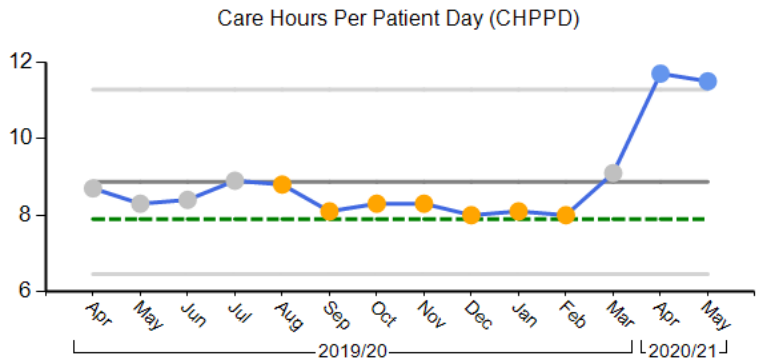


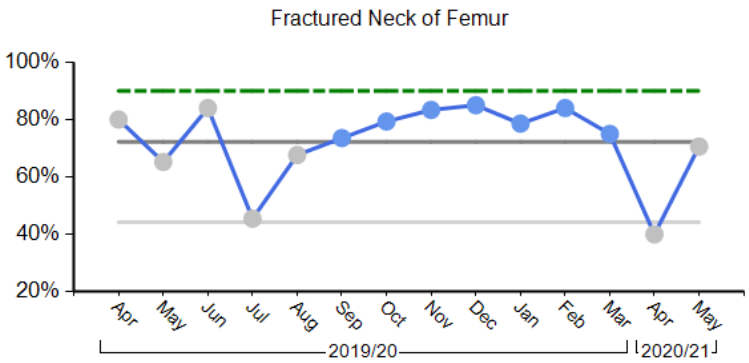
Sepsis - Timely Identification



Sepsis - Timely Treatment




Care Hours Per Patient Day (CHPPD)
12
10
8
6
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2019/20
2020/21


Fractured Neck of Femur
100%
80%
60%
40%
20%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2019/20
2020/21

Quality

Infection Prevention and Control

To note the RCA process for IPC is currently under review

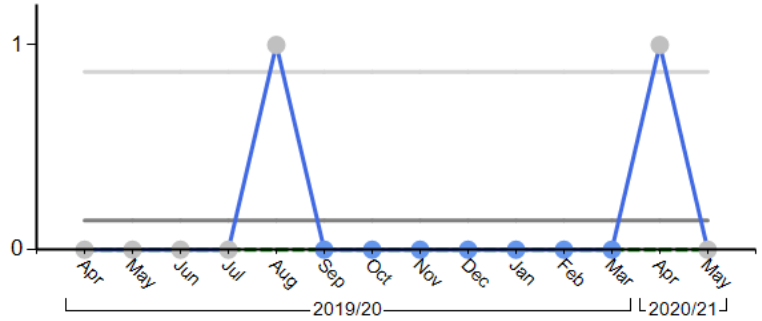
Clostridium difficile

3 cases were reported in month. There were no lapses of care identified in 2 cases. A lapse of care was identified related to prompt isolation.

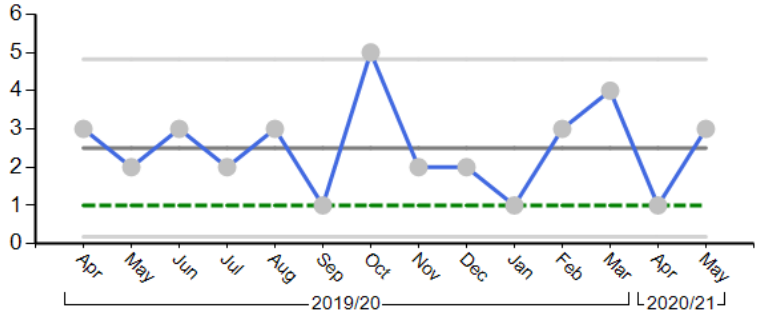
A review of 2019/20 Clostridium difficile cases and performance is included in the infection Control Annual report at Board as part of the business cycle.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	May 20		0	1	Apr 20	0	1	
C-Diff	1	3	3	May 20		1	1	Apr 20	15	4	
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	9	N/A	May 20		6.9	9.4	Apr 20			
E. Coli	2	2	2	May 20		2	2	Apr 20	2	4	

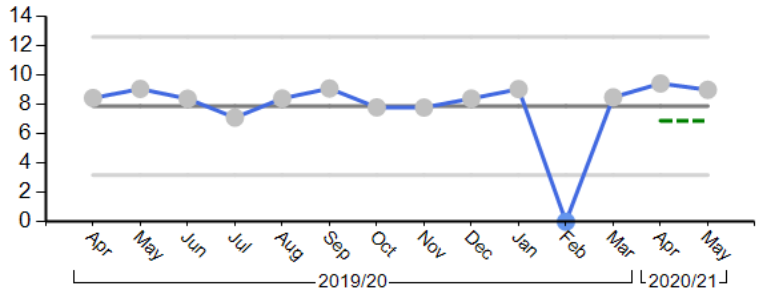
MRSA



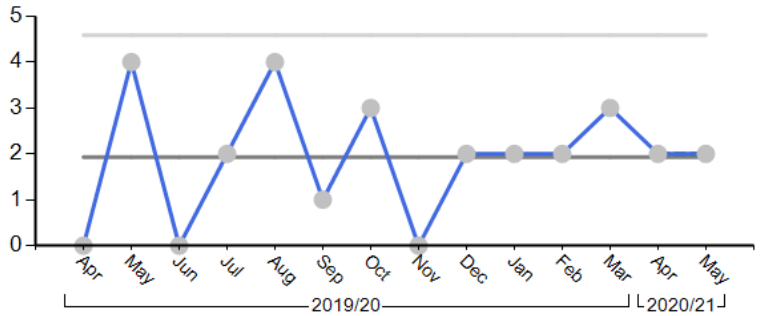
C-Diff



MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)



E. Coli



Quality

Maternity

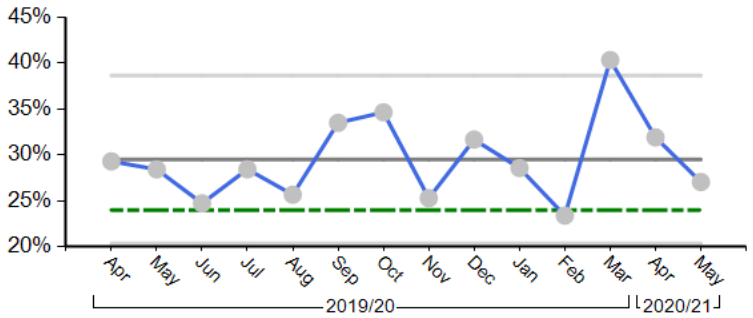
C section rates have reduced over last 2 months

95% of inductions are clinically indicated. Increased awareness of the poor fetal outcomes associated with reduced fetal movements and growth has led to significant increase in early induction of labour. Maternal request accounts for 5% of inductions which is the only indication that is not evidence based.

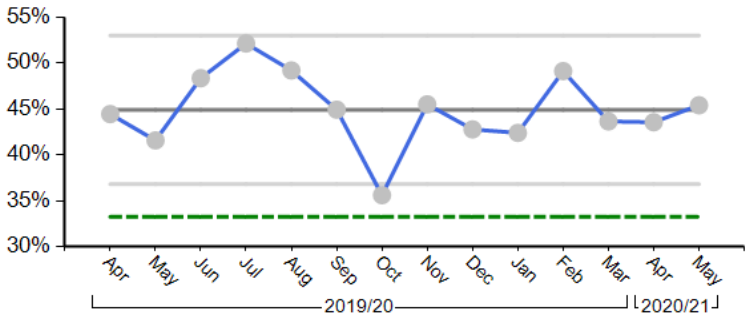
The trust C section rates are in line with regional rates

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Caesarean Rates	24%	27%	53	May 20		24%	31.9%	Apr 20	24%	29.2%	
Induction Rate	33.3%	45.4%	89	May 20		33.3%	43.6%	Apr 20	33.3%	44.6%	
Breastfeeding Initiation	60%	60.7%	77	May 20		60%	71.2%	Apr 20	60%	65.5%	
Percentage of Women Booked by 12 weeks 6 days	90%	95.1%	9	May 20		90%	95.5%	Apr 20	90%		
Number of Occasions 1:1 Care Not Provided			0	May 20				Apr 20			
Percentage of 3rd/4th Degree Tears	0	1	1	May 20		0	1	Apr 20	0	2	
Number of Maternal Deaths	0	0	0	May 20		0	0	Apr 20	0	0	
Number of Maternity Complaints	0	0	0	May 20		0	0	Apr 20	0	0	

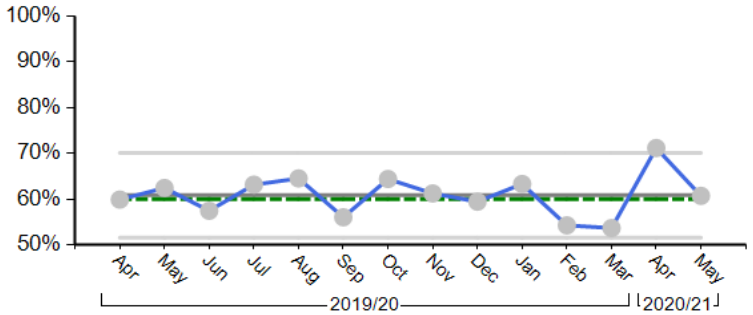
Caesarean Rates



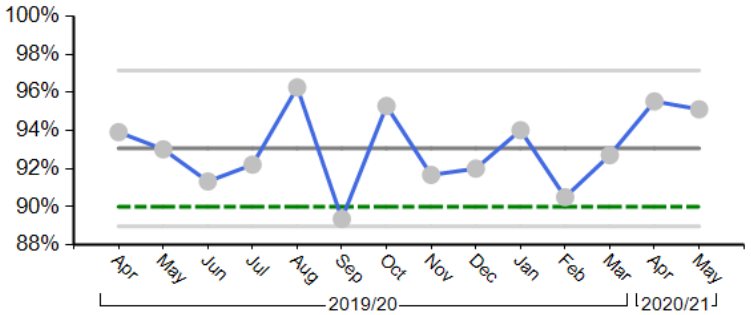
Induction Rate



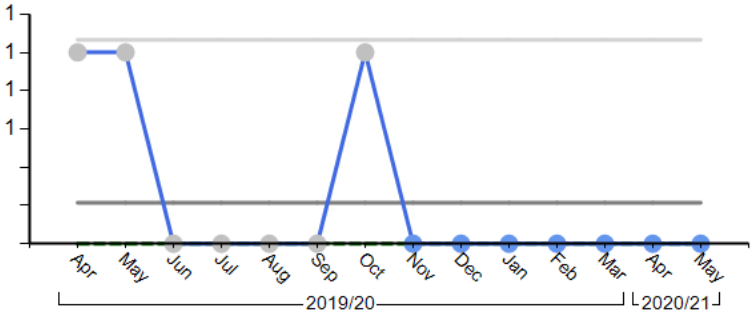
Breastfeeding Initiation



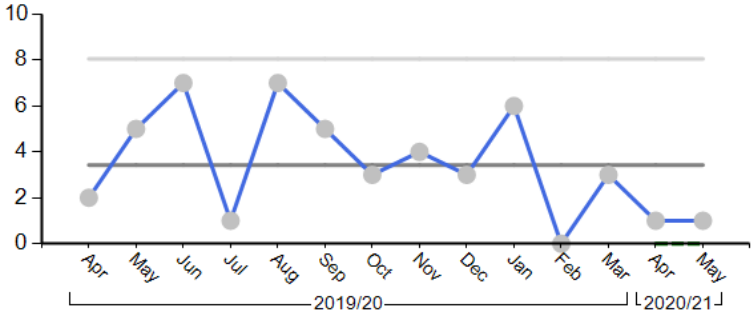
Percentage of Women Booked by 12 weeks 6 days

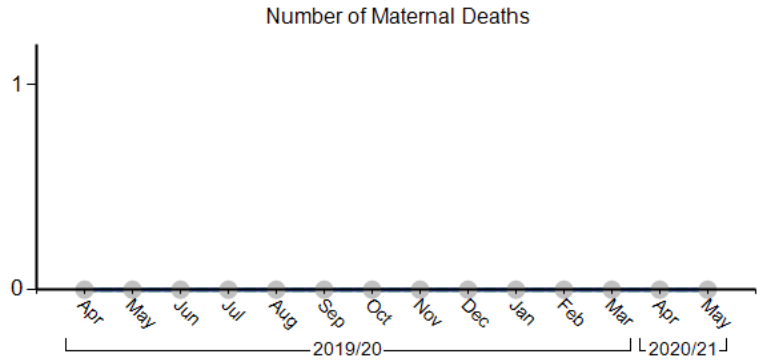


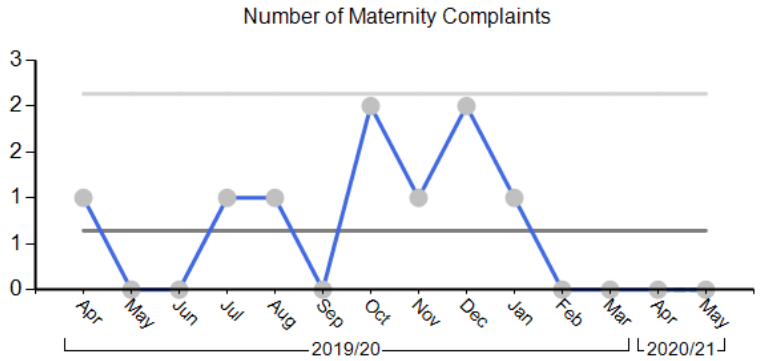
Number of Occasions 1:1 Care Not Provided



Percentage of 3rd/4th Degree Tears




Number of Maternal Deaths
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2019/20
2020/21

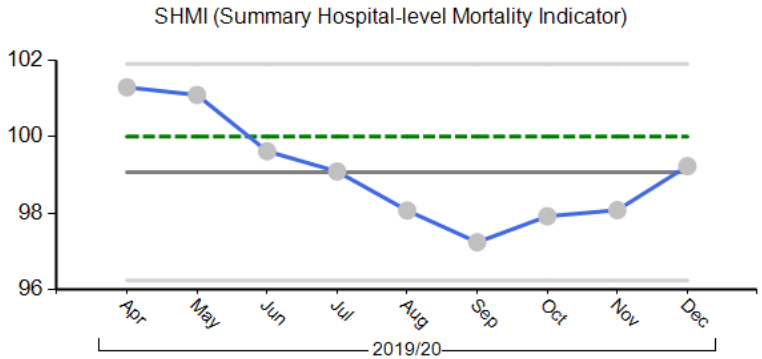

Number of Maternity Complaints
3
2
2
1
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2019/20
2020/21

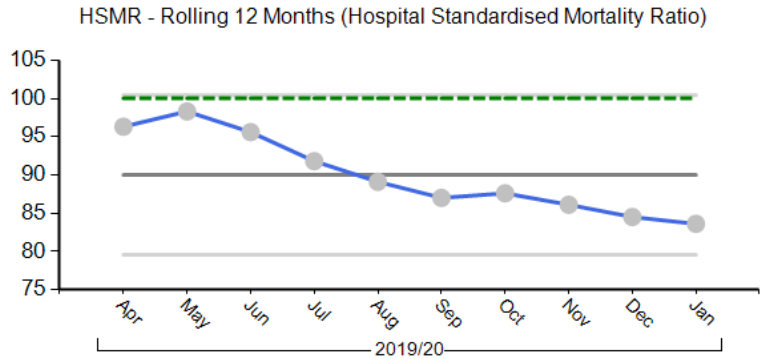
Quality

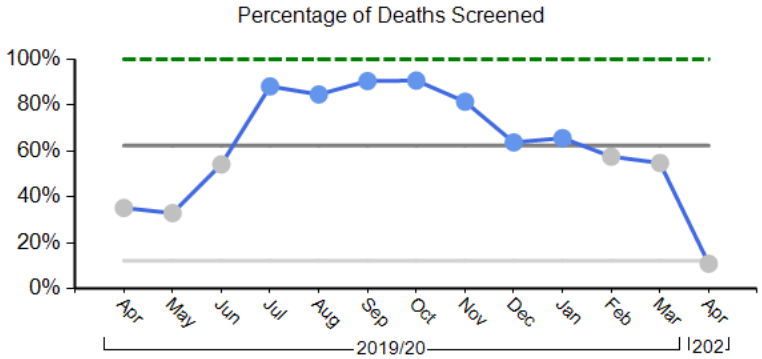
Mortality

Percentage of deaths screened. Lowest ever figure. Screening and reviewing will only be resolved with appointment of medical examiner as per national guidance

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	99.2	N/A	Dec 19		100	98.1	Nov 19	100	99.1	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	83.6	N/A	Jan 20		100	84.5	Dec 19	100	83.6	
Percentage of Deaths Screened	100%	10.9%	131	Apr 20		100%	54.8%	Mar 20	100%	10.9%	







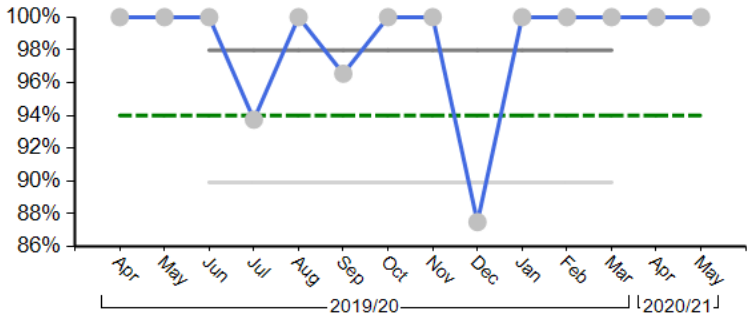
Quality

Patient Experience

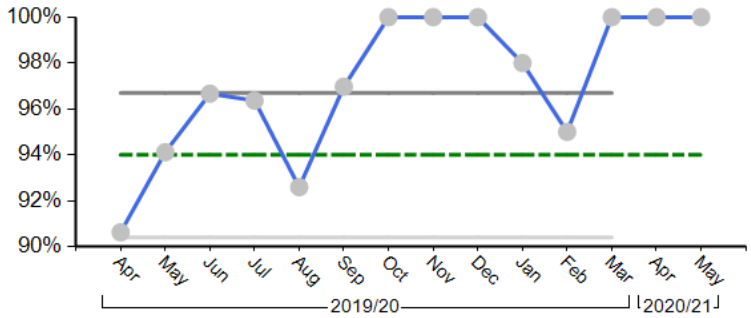
There has been a reduction in month in FFT response rates as a result of paper and IPAD responses for inpatients being stopped during COVID. The text service in place for other parts of the trust has been extended to inpatient areas. Initial results are indicating responses rates are increasing as a result of this intervention.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Friends & Family - % That Would Recommend - AnteNatal Community	94%	100%	0	Mar 20		94%	100%	Feb 20	94%		
Friends & Family - % That Would Recommend - Labour Ward	94%	100%	0	Mar 20		94%	95%	Feb 20	94%		
Friends & Family - % That Would Recommend - Post Natal Ward	94%	100%	0	Mar 20		94%	100%	Feb 20	94%		
Friends & Family - % That Would Recommend - Post Natal Community	94%	100%	0	Mar 20		94%	100%	Feb 20	94%		
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	0	0	May 20		0	0	Apr 20	0	0	
Written Complaints	35	6	6	May 20		35	10	Apr 20	537	16	
Complaints Average Turnaround Time	40	56	N/A	May 20		40	47	Apr 20	40	103	
Duty of Candour - Evidence of Discussion	100%	100%	0	May 20		100%	100%	Apr 20	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	May 20		100%	100%	Apr 20	100%	100%	
Friends and Family Test - Staff - % That Would Recommend - Trust Overall		65.3%	124	Sep 19			69.2%	Jun 19		66%	

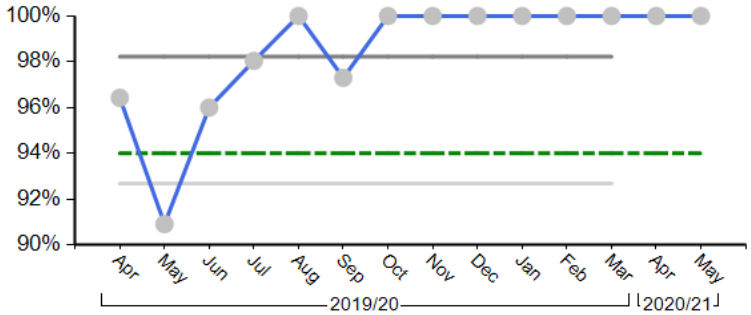
Friends & Family - % That Would Recommend - AnteNatal Community



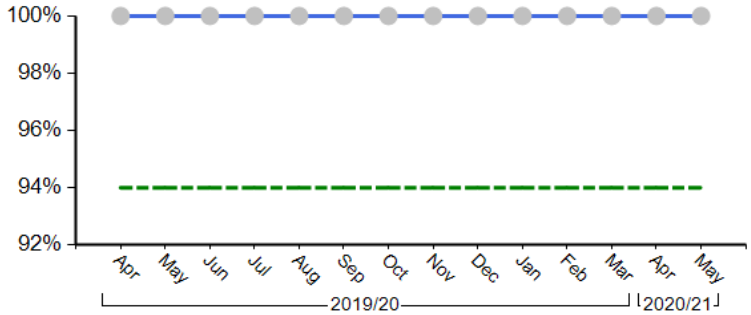
Friends & Family - % That Would Recommend - Labour Ward



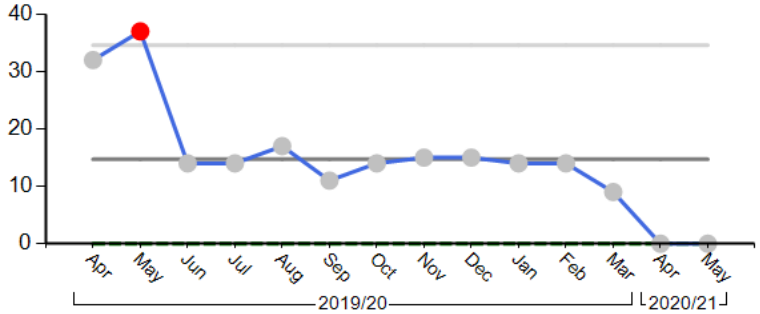
Friends & Family - % That Would Recommend - Post Natal Ward



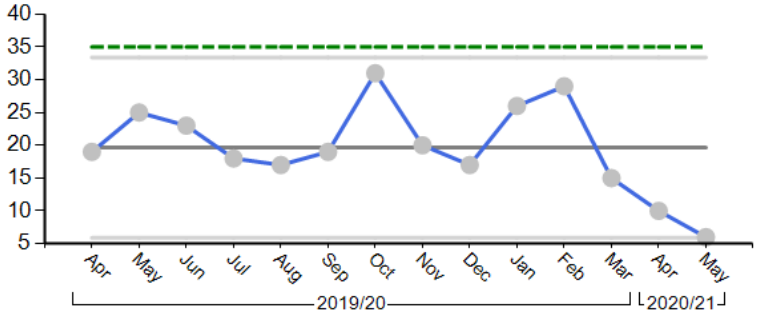
Friends & Family - % That Would Recommend - Post Natal Community



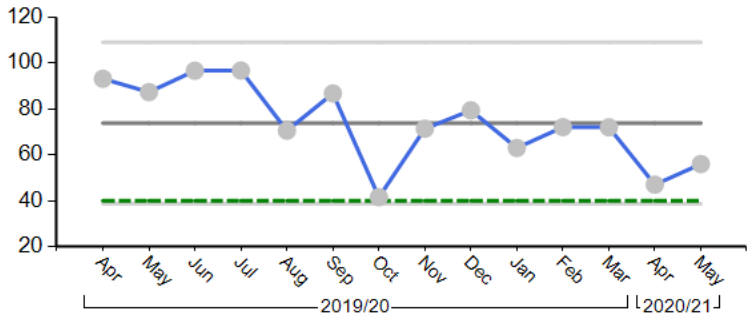
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



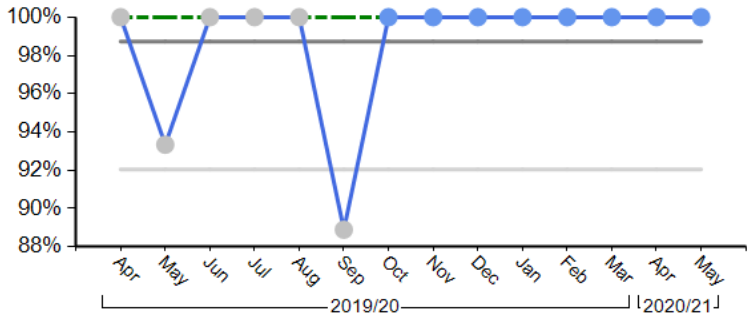
Written Complaints



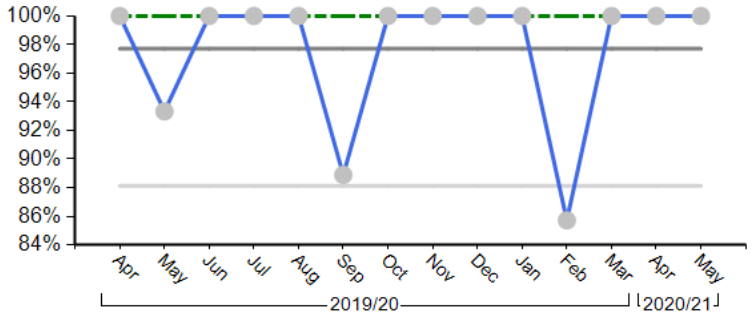
Complaints Average Turnaround Time



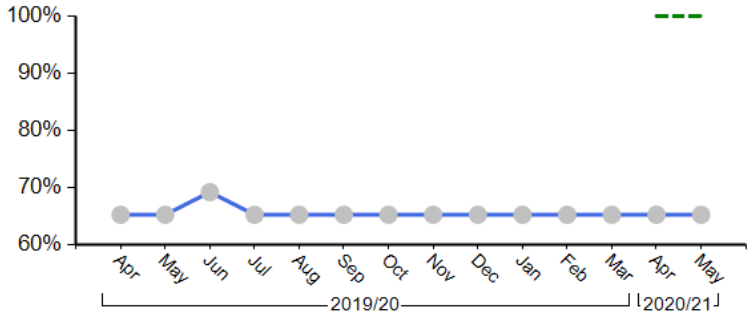
Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Friends and Family Test - Staff - % That Would Recommend - Trust Overall



Operations

Access

Urgent & Emergency Care:
The Trust reported that 95.9% of patients were seen, treated and either transferred or discharged from ED. The Trust performance ranked 35 (out of 128) nationally and ranked 4 (out of 20) for the North West region. A key contributor was the lower levels of ED attendances on both sites however this alone would not have delivered the performance. This lower levels of ED attendances was significantly supported by the system ability to maintain effective patient flows. The fact that patients following a Decision To Admit (DTA) could be transferred out of the department within4 hours plays a critical role in delivering good performance. Key actions to maintain patient flows:

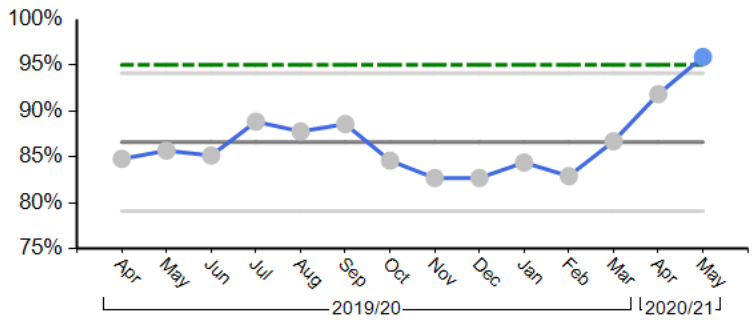
- Daily senior clinical reviews have been maintained throughout the pandemic in all clinical settings.
- The Trust planned for reduction/cessation of face to face out-patient activity to support senior clinical leadership and decision making
- Weekly 'Grand Round' with Consultant, Head of Patient Flow and Therapy manager to 'check, chase and challenge' at ward level
- Daily MDT huddles have been maintained with community partners throughout the pandemic, supported by the CCG Programme Director Urgent Care.
- The discharge lounge was relocated to Ward 1 in March to support social distancing for patients and staff.
- Development of 'MOFD'(safe to transfer) spreadsheet to ensure monitoring of all patients and new During April there was funding secured to introduce the Integrated Discharge Planning Team. This team is led by senior staff from the ASC and community settings.
- Re-engagement with Strata to support electronic referral and pathway for discharge will go live June 15th 2020.
- Utilisation of Ormskirk capacity for Covid-19 positive patients requiring further rehabilitation
- Engagement with Renacres to open non-Covid rehabilitation beds for patients who are not able to be discharged into the community bed base
- CCG commissioned community beds to support step-down from Acute in support of Annex B, initially in Sefton 12th May and in West Lancs 25th May in Hesketh Park and Fornby Manor

RTT:
RTT performance has decreased as expected but, with current performance only dropping to 73%. Whilst GP referrals has seen a sharp which has led to an overall reduction on the RTT waiting list the numbers o long waiters have grew exponentially. This is down to the NHS England mandate to defer non-urgent clinical activity from the beginning of April 2020. The number of waiters over 30 weeks is currently 488 and continues to increase. This number is nearly 5 times the previous average. The Trust has significant issues with Gynaecology due to historical workforce issues that have been further compounded due to COVID-19. The Trust declared one 52 week breach for May in Gynaecology with the patient choosing to defer elective surgery. The NHS overall reported 11,000 52 week breaches for the last month of reporting which highlights the extent and profound impact of COVID-19 nationally. National guidance around swabbing of patients prior to elective surgery was received with the requirement for 14 days isolation prior to the TCI date. This has already shown to be an issue with patients refusing to isolate due to social and economic factors. Current guidance is that patients who refuse due to covid fears or failure to isolate must remain on Waiting Lists thus increasing chance of 52 week breaches. On a positive discussions with the Independent Sector continue and Trust endoscopy is expected to commence at Renacres from mid-June. Work is also ongoing with the clinical teams to improve throughput of elective theatres. From the 15th June, four theatre lists will be offered per day (Monday to Thursday) at Ormskirk, with three of those lists for urgent and long wait elective cases. One list continues to deliver a combined Trauma / Emergency Surgery list. It is expected that each specialty should get at least one additional full day of surgery per week.

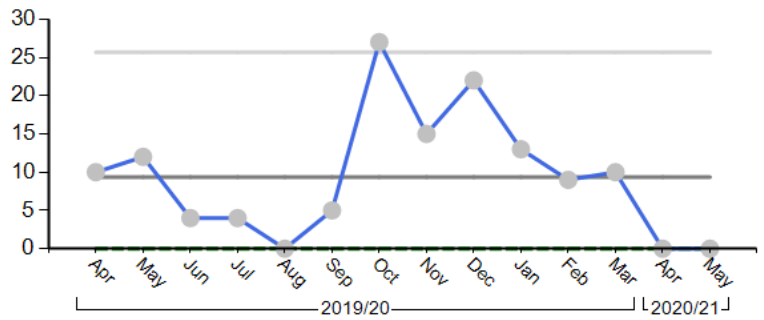
Diagnostics:
Diagnostic performance has deteriorated to 57.61% in May. The rate of decline seen in April has subsided which is a positive adjustment. The highest number of long waiters are for non-obstetric ultrasound (524), ECG's (262) and Audiology (172). Work is ongoing to address the performance across all diagnostic areas.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	95.9%	248	May 20		95%	91.8%	Apr 20	95%	94.2%	
Accident & Emergency - 12+ Hour trolley waits	0	0	0	May 20		0	0	Apr 20	0	0	
Ambulance Handover 30-60 Mins	0	19	19	May 20		0	15	Apr 20	0	34	
Ambulance Handover Over 60 Mins	0	0	0	May 20		0	0	Apr 20	0	0	
Referral to treatment: on-going	92%	73%	1749	May 20		92%	82.1%	Apr 20	92%	77.9%	
52 Week Waits	0	1	1	May 20		0	0	Apr 20	0	1	
Diagnostic waits	1%	57.6%	1537	May 20		1%	50.6%	Apr 20	1%	55.2%	
Stroke - 90% Stay on Stroke Ward	80%	72.7%	6	May 20		80%	74.1%	Apr 20	80%	73.5%	
TIA	60%	40%	3	May 20		60%	60%	Mar 20	60%	40%	
Cancelled Operations	0.6%	0%	0	May 20		0.6%	0.2%	Apr 20	0.6%	0.1%	

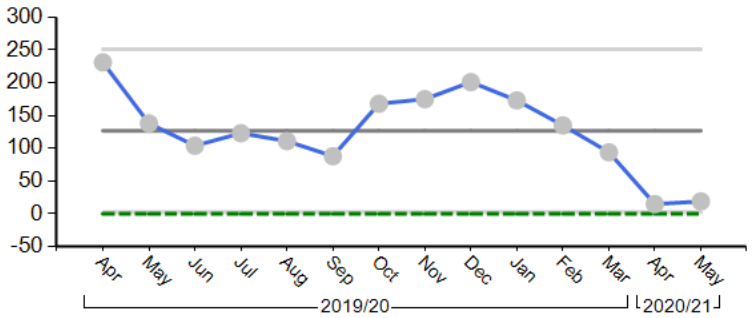
Accident & Emergency - 4 Hour compliance



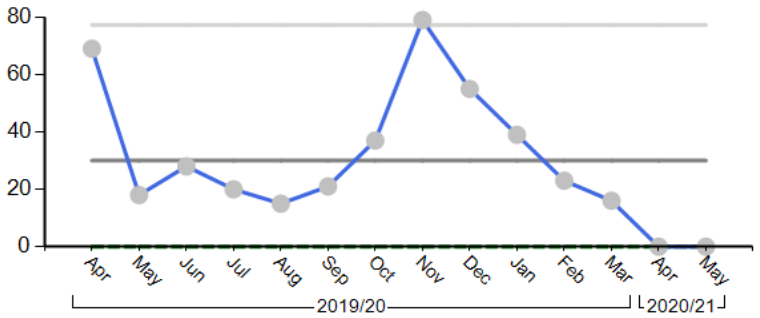
Accident & Emergency - 12+ Hour trolley waits



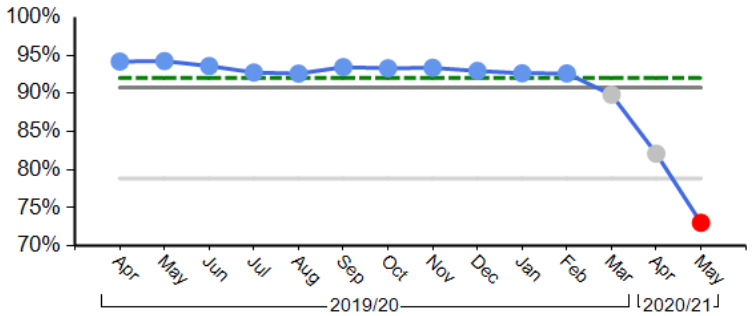
Ambulance Handover 30-60 Mins



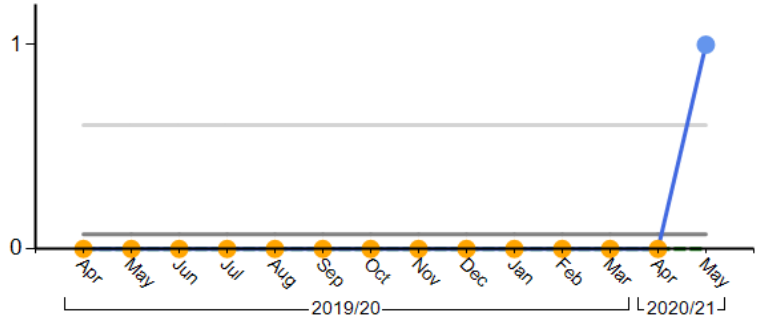
Ambulance Handover Over 60 Mins



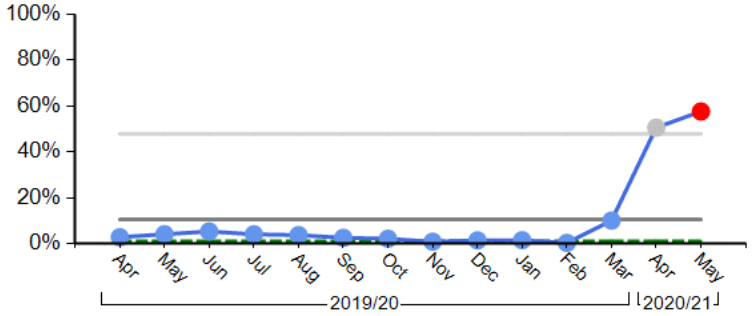
Referral to treatment: on-going



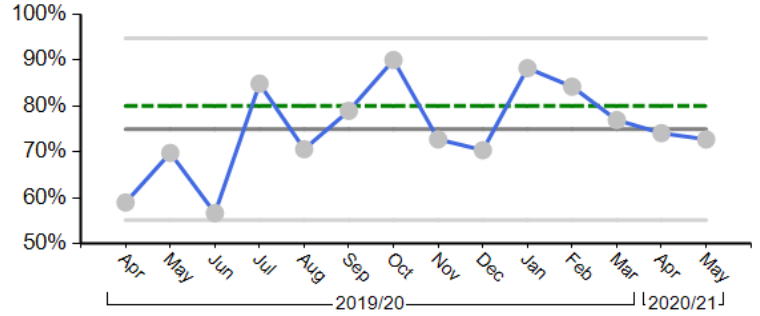
52 Week Waits

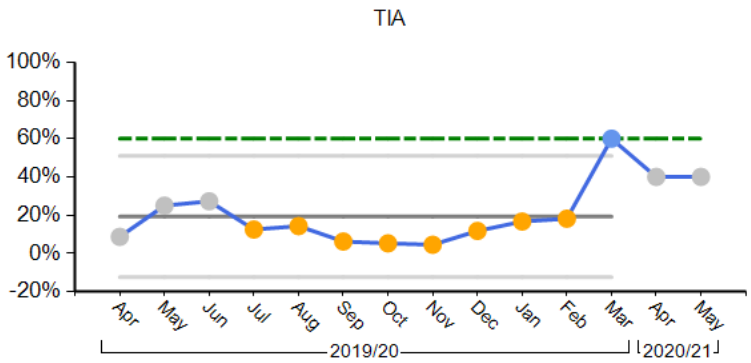


Diagnostic waits



Stroke - 90% Stay on Stroke Ward




TIA
100%
80%
60%
40%
20%
0%
-20%
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May
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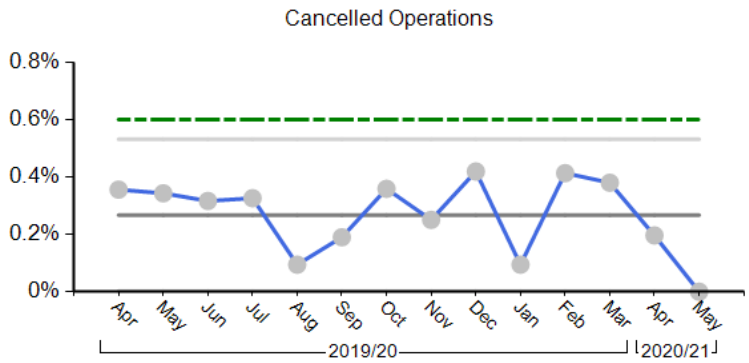
May
2019/20
2020/21


Cancelled Operations
0.8%
0.6%
0.4%
0.2%
0%
Apr
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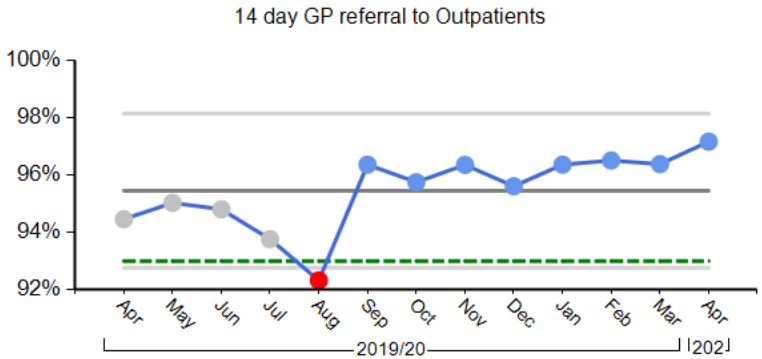
Mar
Apr
May
2019/20
2020/21

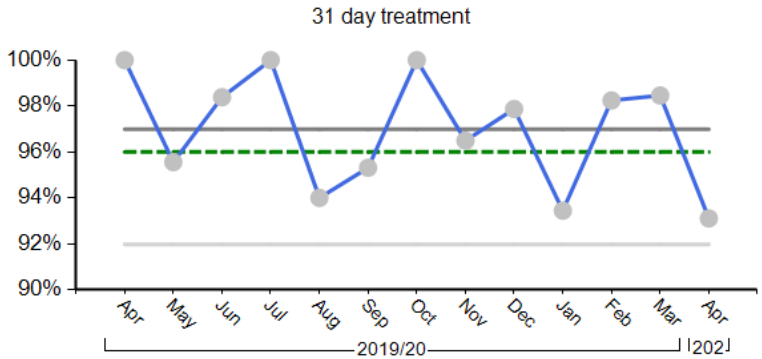
Operations

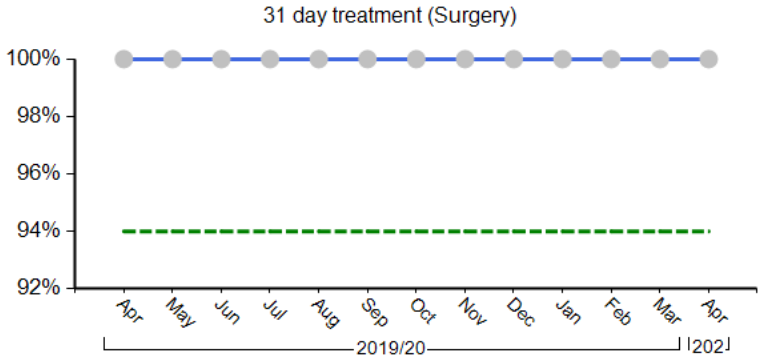
Cancer

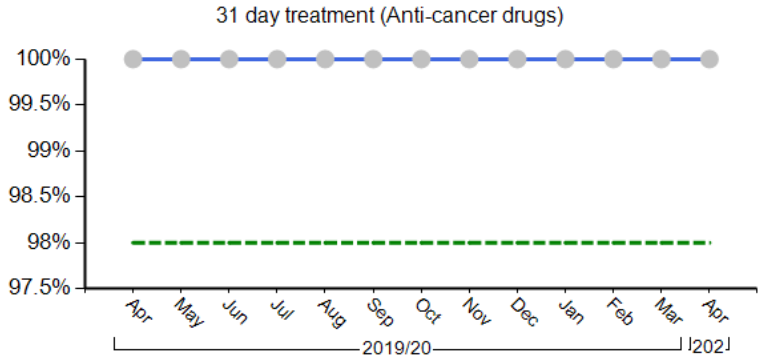
Cancer:
Despite a fall in National 62 day cancer performance for S&O this month, we have maintain our average accountable treatments, meaning we were able, during April, to treat our usual number of cancer patients. We were able to do this by maintaining the stance of not suspending any cancer investigations or surgeries during the COVID lockdown period, as well as robust tracking and visualisation at patient level detail of the whole cancer PTL. Our performance has fallen due to a delay in referrals from S&O to tertiary centres and then a further delay at tertiary due to suspension of some cancer diagnostics and surgeries elsewhere within the region. This detail will be established during the routine RCA process within S&O. Throughout the outbreak Cancer Services have maintained a full and robust cancer pathway for all 2 week wait referrals. In line with national guidance all clinical teams risk stratified all new referrals as well as those already on a pathway to ensure the most urgent patients were prioritised for treatment and diagnostics. This process continues and has meant we have been able to maintain a proactive treatment list within the Trust without using the appointed regional Cancer Hubs. We appointed a retired S&O surgeon to act as the Clinical Lead for cancer to represent S&O voice in the regional Cancer Alliance recovery plan. The Cancer Trackers have continued to track monitor and escalate within Trust guidelines for all cancer pathways patients despite the reduced number of referrals. Cancer Services have established and maintained a patient level detail Patient Tracking List (PTL) to ensure all patients, including those that wish to defer due to COVID, are monitored and reviewed on a daily basis. This daily PTL had enabled S&O to ensure those that are willing to engage are supported through their pathways, as well as those that wish to defer are regularly reviewed and clinically assessed on a regular basis. Cancer Services have supported the clinical teams in new ways of working during the pandemic lockdown, including telephone consultations and results clinics, as well as implementation of FIT testing as first investigation for bowel cancer. Self Supported Management pathways in prostate and colorectal cancers have proven to reduce the number of patients attending clinic appointment but will continue to have the necessary clinical support in an easy to access way. This process has been funded for another year by the CCGs. We are currently reviewing Haematology patients to move towards a self supported management programme for low risk cancer patients too. Activity over the last month (May) has shown we have maintained an activity level which saw 57 of our cancer patients treated.

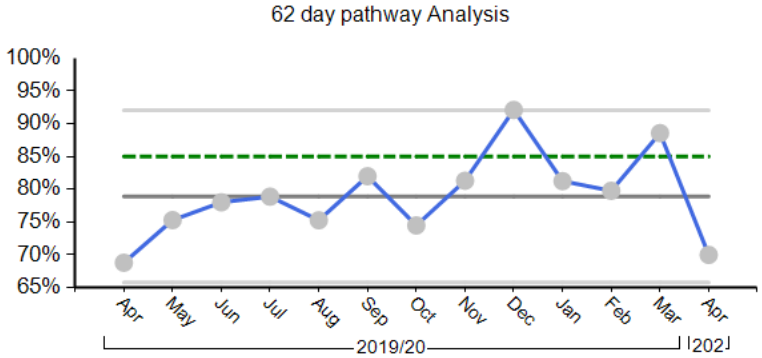
	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	97.2%	9	Apr 20		93%	96.4%	Mar 20	93%	97.2%	
31 day treatment	96%	93.1%	4	Apr 20		96%	98.5%	Mar 20	96%	93.1%	
31 day treatment (Surgery)	94%	100%	0	Mar 20		94%	100%	Feb 20	94%	100%	
31 day treatment (Anti-cancer drugs)	98%	100%	0	Jan 20		98%	100%	Sep 19	98%	100%	
62 day pathway Analysis	85%	70%	13.5	Apr 20		85%	88.6%	Mar 20	85%	70%	
62 day GP referral to treatment	85%	70%	13.5	Apr 20		85%	88.6%	Mar 20	85%	70%	

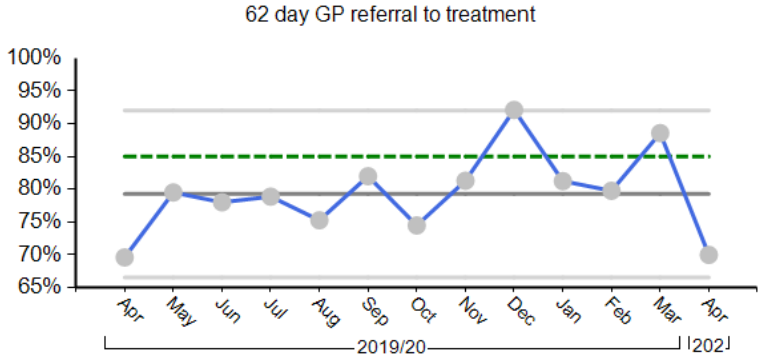

14 day GP referral to Outpatients
100%
98%
96%
94%
92%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202


31 day treatment
100%
98%
96%
94%
92%
90%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202


31 day treatment (Surgery)
100%
98%
96%
94%
92%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202


31 day treatment (Anti-cancer drugs)
100%
99.5%
99%
98.5%
98%
97.5%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202


62 day pathway Analysis
100%
95%
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202


62 day GP referral to treatment
100%
95%
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
2019/20
202

Operations

Productivity

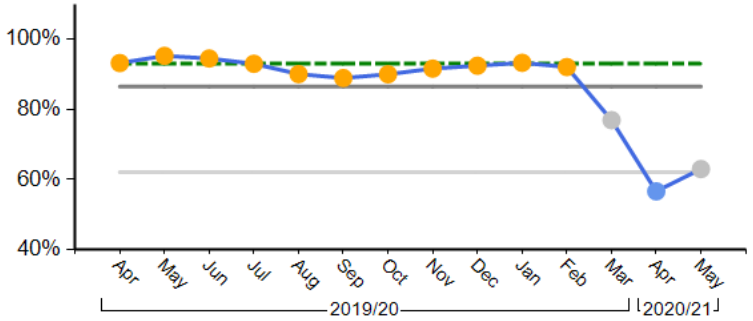
Operational Productivity:
It must be noted that theatre and outpatient productivity will be impacted upon due to the profoundness of COVID-19 and the need to deliver safe and effective services. Whilst every effort will be made to ensure theatre and outpatient services are efficient there are factors that will inhibit our ability to deliver the internal KPI ambitions set pre COVID-19. All planning and reintroduction of activity is based on a number of factors::

- Availability of our Workforce;
- Our estate and the effect of social distancing measures on capacity;
- Adapted processes to ensure maximum staff and patient safety;
- Localised Specialty Specific Royal College Guidance;
- Any effect on admissions due to the relaxation of lockdown measures.

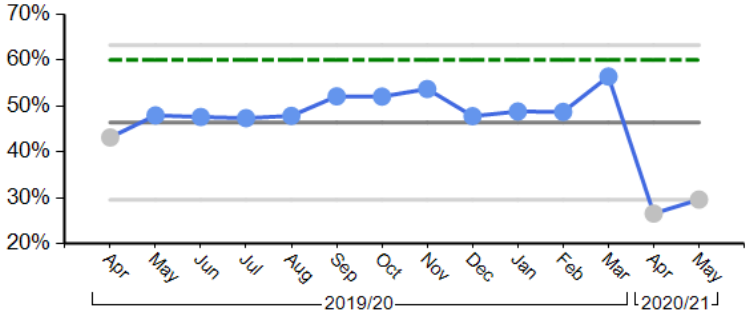
It is expected that the amazing advances that have been achieved in regards change of work practices and the use of digital technology will play a crucial role in delivering our business with Covid.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	93%	63%	N/A	May 20		93%	56.6%	Apr 20	93%	60%	
Bed Occupancy - ODGH	60%	29.6%	N/A	May 20		60%	26.6%	Apr 20	60%	28.1%	
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	38	38	May 20		50	25	Apr 20	50	32	
Stranded Patients (>6 Days LOS)	170	122	122	May 20		170	104	Apr 20	170	226	
Super Stranded Patients (>20 Days LOS)	58	41	41	May 20		58	33	Apr 20	58	74	
New:Follow Up	2.63	2.6	N/A	May 20		2.6	2.8	Apr 20	2.6	2.7	
DNA (Did Not Attend) rate	8%	4.5%	554	May 20		8%	4%	Apr 20	8%	4.2%	
Theatre Utilisation - SDGH	85%	58%	N/A	May 20		85%	45.9%	Apr 20	85%	51.9%	
Theatre Utilisation - ODGH	95%	48.2%	N/A	May 20		95%	29.7%	Apr 20	95%	39.4%	
Southport A&E Conversion Rate	20%	26.4%	946	May 20		20%	33.8%	Apr 20	20%		

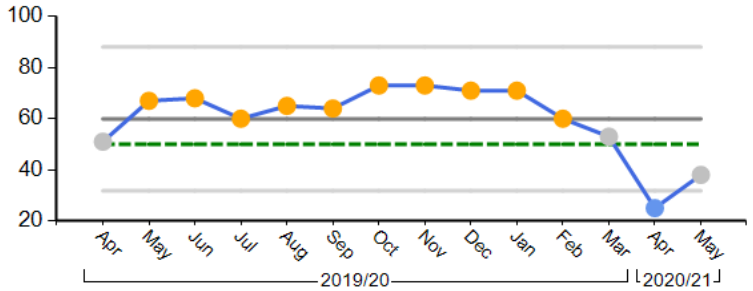
Bed Occupancy - SDGH



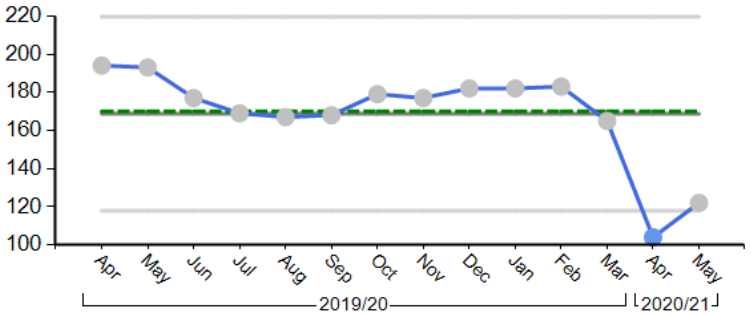
Bed Occupancy - ODGH



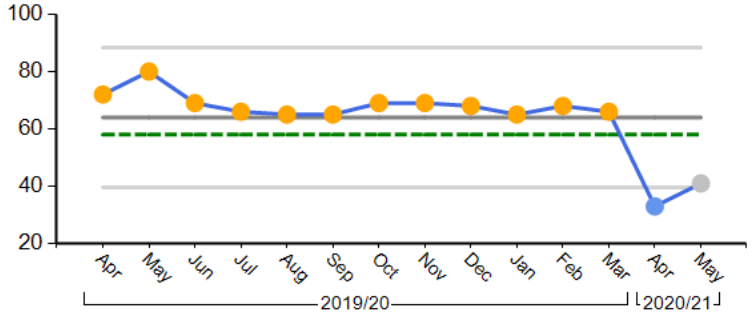
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month



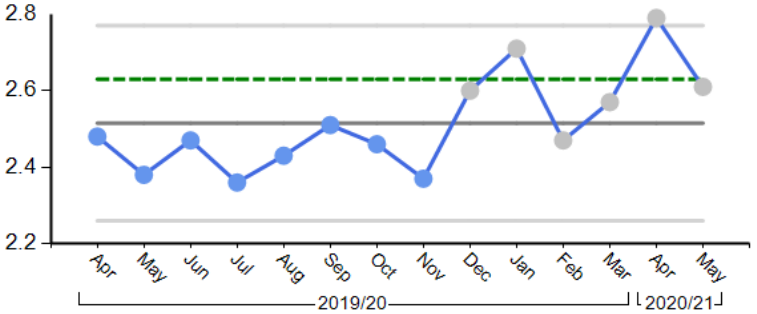
Stranded Patients (>6 Days LOS)



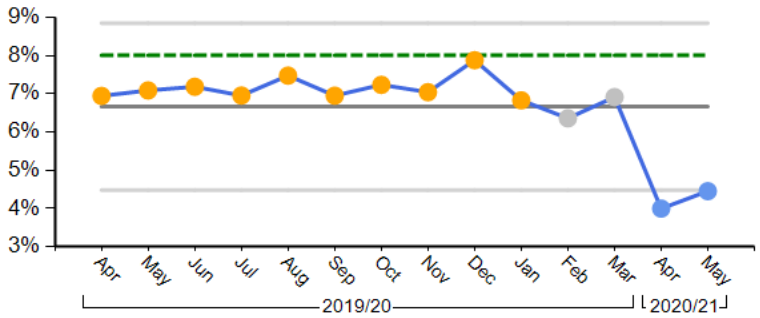
Super Stranded Patients (>20 Days LOS)



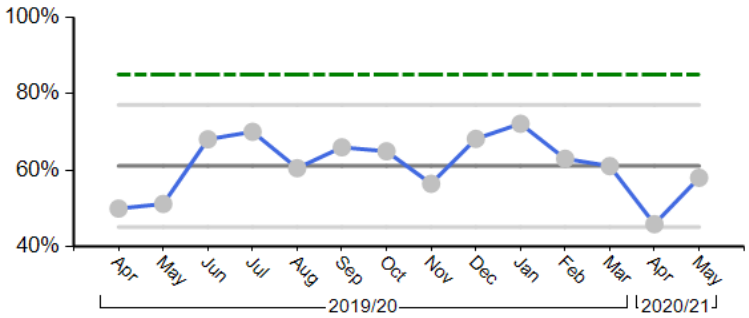
New:Follow Up



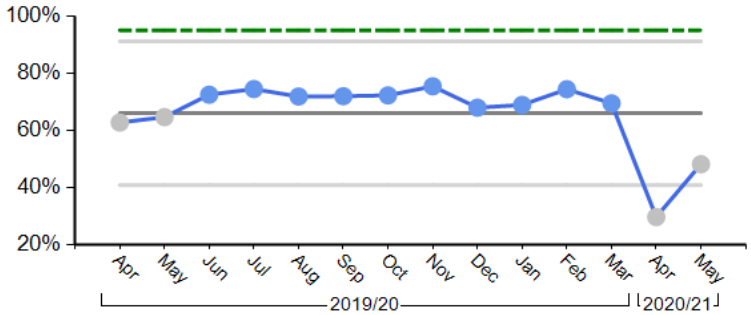
DNA (Did Not Attend) rate



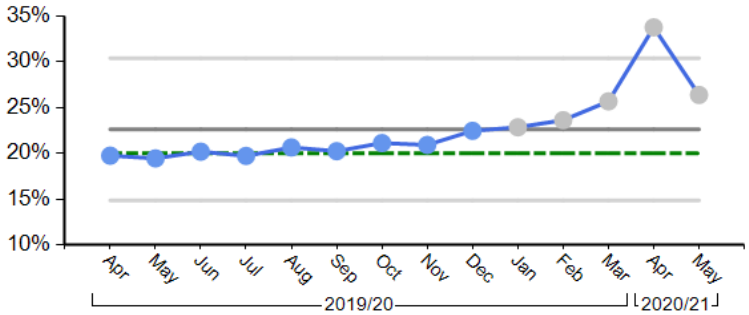
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate

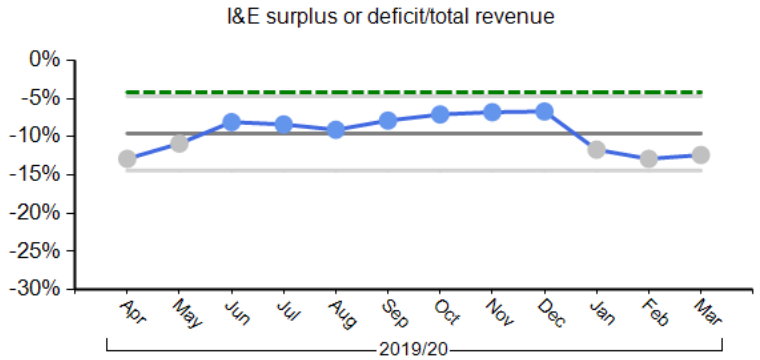


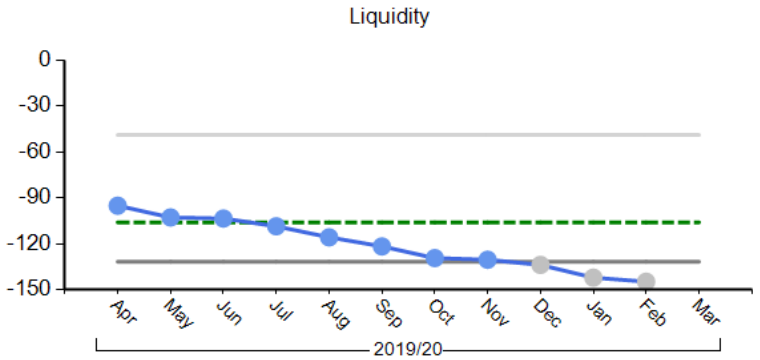
Finance

Finance

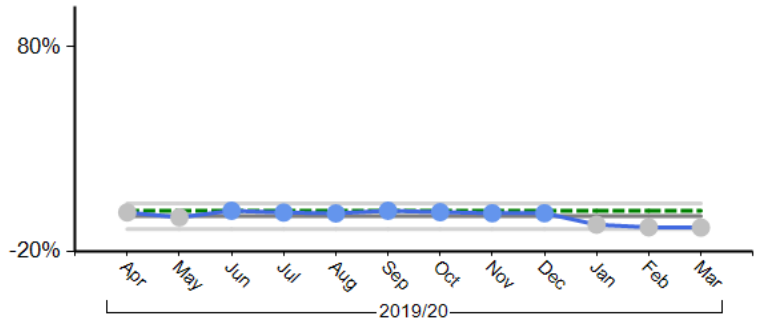
As reported last month with the suspension of the 2020/21 Operational Planning process and a new financial framework introduced for the period 1st April to 31st July the only metric being measured nationally is Agency Spend as the funding formula of block and top-up payments including any additional marginal costs due to COVID-19 means the Trust is reporting break even on a monthly basis.
In month 2, agency spend was £1.115 million (month 1 £0.999 million) 8.6% (month 1 8.0%) of the total paybill. This included COVID-19 related agency spend of £0.214 million (month 1 £0.158 million).

	Latest					Previous			Year to Date		Target
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
I&E surplus or deficit/total revenue	-4.19%	-12.4%	N/A	Mar 20		-4.2%	-12.9%	Feb 20	-4.2%	-12.4%	
Liquidity	-106	-253	N/A	Mar 20		-106	-145	Feb 20	-106	-253	
Distance from Control Total	0%	-8.2%	N/A	Mar 20		0%	-8.1%	Feb 20	0%	-8.2%	
Capital Service Capacity	0.2	-1.216	N/A	Mar 20		0.2	-1.063	Feb 20	0.2	-1.216	
% Agency Staff (cost)	5%	8.6%	N/A	May 20		5%	8%	Apr 20	5%	8.3%	
Use of Resources (Finance) Score	3	4	N/A	Mar 20		3	4	Feb 20		3	
Distance from Agency Spend Cap	0%	167%	N/A	Mar 20		0%	166%	Feb 20	0%	167%	

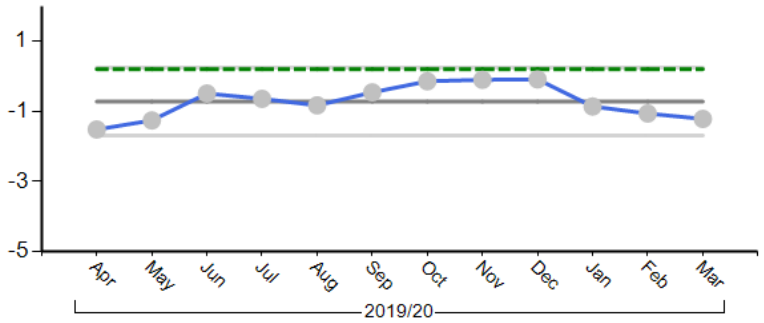




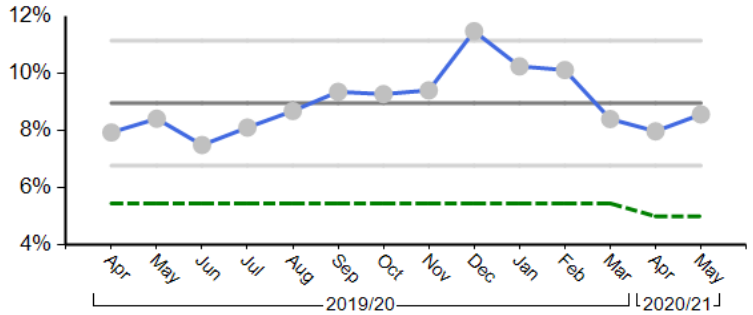
Distance from Control Total



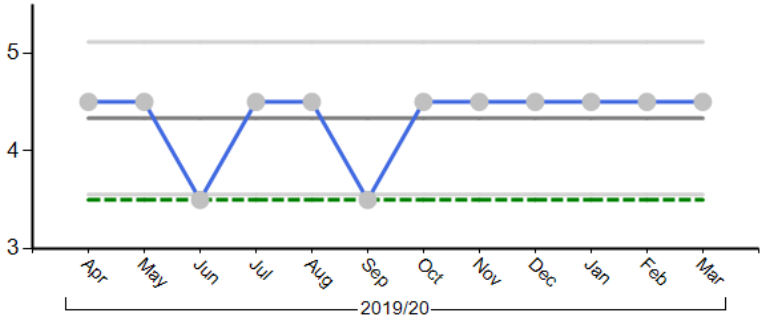
Capital Service Capacity



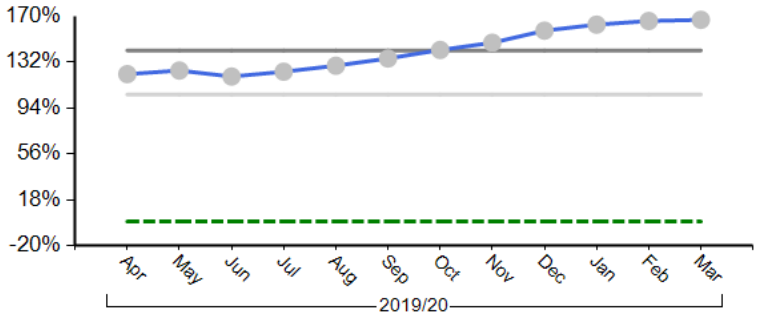
% Agency Staff (cost)



Use of Resources (Finance) Score



Distance from Agency Spend Cap

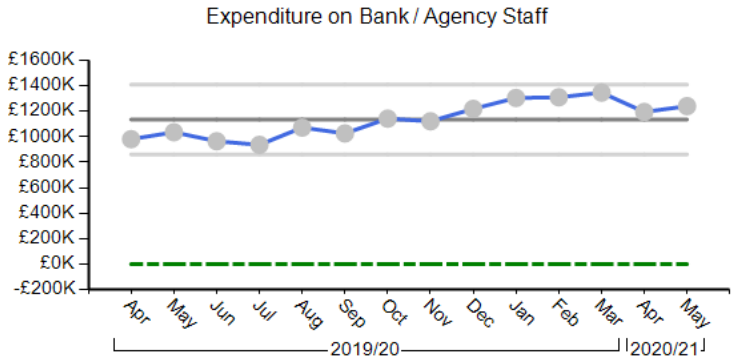


Workforce

Agency

Bank & Agency spend - temporary staffing spend increased in all staff groups. It should be noted that a significant reduction in agency and was achieved in other medical however this was offset by increased agency utilisation in all other staff groups.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Expenditure on Bank / Agency Staff	£00K	£1,239K	N/A	May 20		£00K	£1,194K	Apr 20		£2,433K	

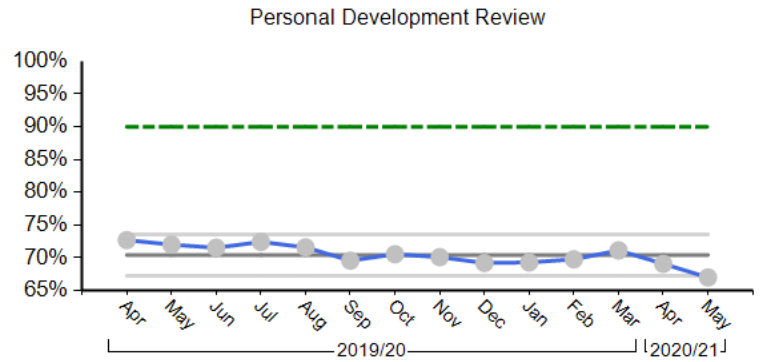


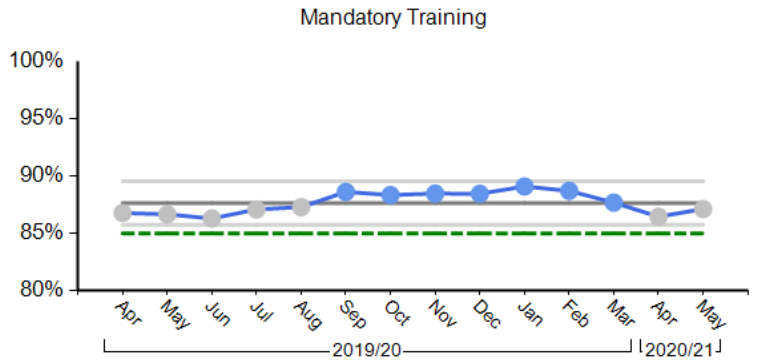
Workforce

Organisational Development

Personal Development Review: The staff survey has shown a deteriorating picture of the quality & compliance of appraisals over several years. In Q2 2020, the OD Team will undertake a survey from a broad cross section of the organisation to understand what the expectations are from a 'quality' appraisal for both staff and managers. The outcomes will determine future development work to bring meaning to appraisals at the trust.
Mandatory Training: During the pandemic, core mandatory training continued online via eLearning this has allowed the Trust to maintain above the Trust 85% target at 87.12% (May 2020). A review of all core mandatory training is now underway to safely re-instate face to face training where no alternative online solution is available. A clinical education review is underway to put in place a clinical skills training programme which is supported by a full TNA and the appropriate resources/team structures to deliver it.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	90%	67%	N/A	May 20		90%	69.1%	Apr 20	90%	68.1%	
Mandatory Training	85%	87.1%	N/A	May 20		85%	86.4%	Apr 20	85%	86.8%	





Workforce

Sickness, Vacancy and Turnover

Medical vacancy rate – the increase in medical vacancy rate is reflective of an error in reporting (bank and agency has previously been included in the report in addition to substantive staff). It should be noted that there has been a significant increase in contracted medical and dental staff due to recruitment activity being realised (102 Consultants compared to 94 Consultants in May 19) and 221 other medical staff (compared to 214 in May 19). The increased in medical staff funding (131 funded consultants compared to 112 and 252 other medical compared to 239). Does not reflect the work that has been ongoing to attract within this staff group. Recruitment and international recruitment continues within this area and medical and dental representation has been included in the development of the recruitment and retention strategy.

Nursing vacancy rate – the decrease in nursing vacancy rate in month reflects the increase in nursing students who have opted in to fixed term contracts with the Trust during the response to Covid 19. There should be particular note that in May 19 our contracted nursing establishment was 1156 wte which has increased to 1262 in May 20. As with medical vacancy rate the funded establishment has also increased which detracts from the progress made (1438 funded May 20 compared to 1386 funded in May 19). It should be noted that the vacancy rate is anticipated to increase again when the student nurses return to education.

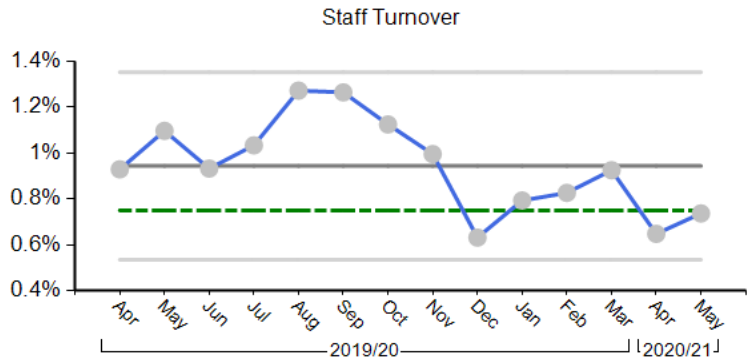
Sickness absence rate: The Covid-19 pandemic has increased the Trust's sickness absence rate since March 2020however the absence rate is starting to decline from its peak in April 2020. This is reflective across all NHS Organisations and the North West is currently highlighted as having some of the highest sickness absence rates which mirrors the regional position as reporting the highest numbers of covid-19 positive patients. Currently there is a national position on the management of Covid-19 related absences whereby they are not counted for monitoring or escalation purposes. This national NHS Employers staff council position is still in position as at May 2020. All covid-19 related absences are recorded separately and the Workforce Team has worked hard over the last 3 months to set up an absence line to ensure real time reporting and also to enable the swabbing POD to ensure a quick return to work for those who test negative and support those who test positive. Workforce Committee have asked for all Covid-19 related absences to be reported on separately going forward and this will be actioned in June 2020.

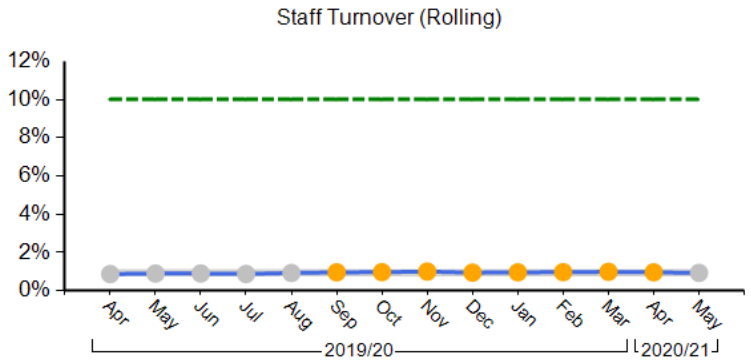
Medical Staff sickness remains high at 9.2 %, this is more than 3 times usual rate.

Staff Turnover: The rolling staff turnover has decreased significantly in May 2020 to 0.9% which is below the Trust target. Staff turnover is not a current focus in the covid-19 workforce response however upon recommencement of the Workforce Improvement Group it has been agreed the proposal for a 2020/21 Strategic work stream that will focus on Attraction, Attrition and Retention Group.

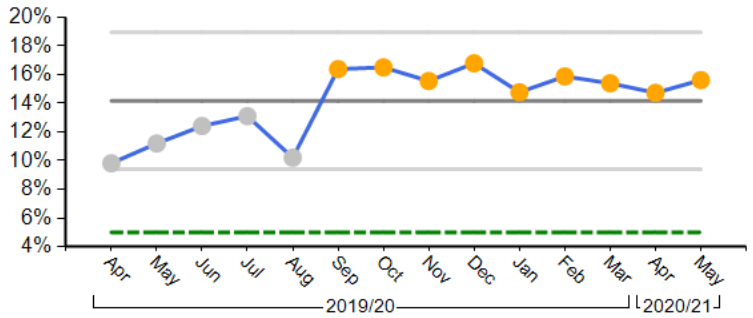
Time to recruit – time to recruit continues to improve and is the lowest achieved and better than target. QI methodology continues to be utilised to support improvements on a sustained basis.

	Latest					Previous			Year to Date		Target
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Staff Turnover	0.75%	0.7%	N/A	May 20		0.8%	0.6%	Apr 20	9%	6.8%	
Staff Turnover (Rolling)	10%	0.9%	N/A	May 20		10%	1%	Apr 20			
Vacancy Rate - Medical	5%	15.6%	N/A	May 20		5%	14.7%	Apr 20	5%		
Vacancy Rate - Nursing	8%	12%	N/A	May 20		8%	14%	Apr 20	8%		
Sickness Rate	4%	6.9%	N/A	May 20		4%	10.6%	Apr 20	5%	8.7%	
Sickness Rate (Rolling 12 Month)	4%	5.9%	N/A	May 20		4%	5.7%	Apr 20	4%	5.8%	
Time to Recruit	30	47	N/A	May 20		30	51	Apr 20	30	49	
Sickness Rate - Medical Staff	4%	3.1%	N/A	May 20		4%	9.2%	Apr 20	4%	6.1%	
Sickness Rate - Nursing Staff	3.7%	8.9%	N/A	May 20		3.7%	13.5%	Apr 20	3.7%	11.1%	
Sickness Rate - Non-Clinical Staff	4%	6.1%	N/A	May 20		4%	7.2%	Apr 20	4%	6.6%	

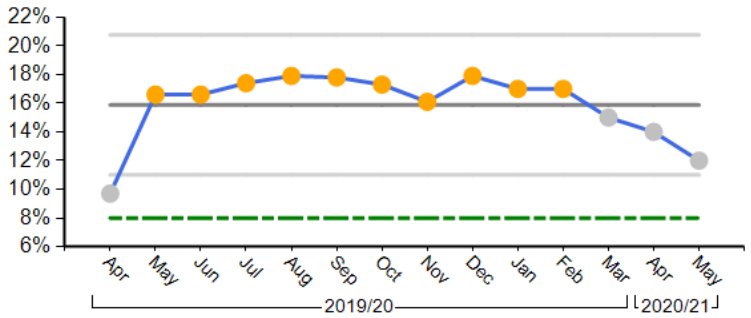




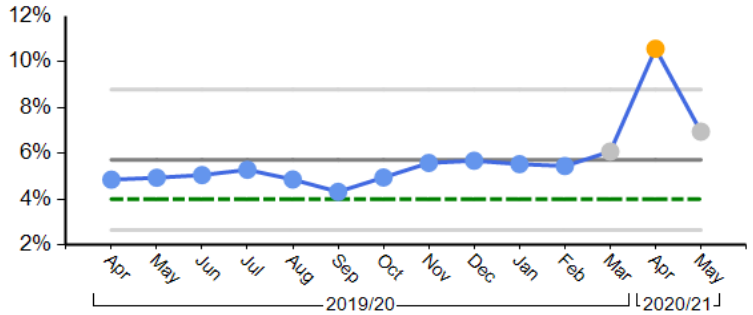
Vacancy Rate - Medical



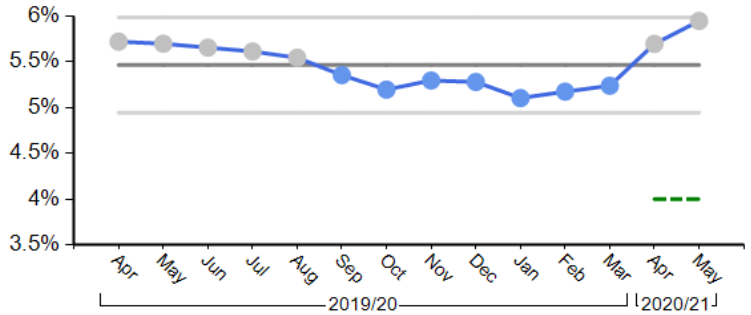
Vacancy Rate - Nursing



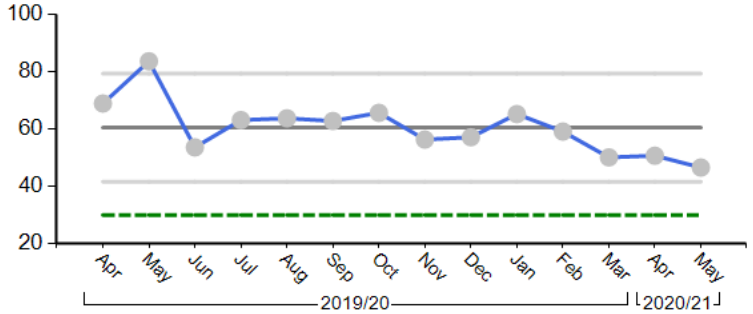
Sickness Rate



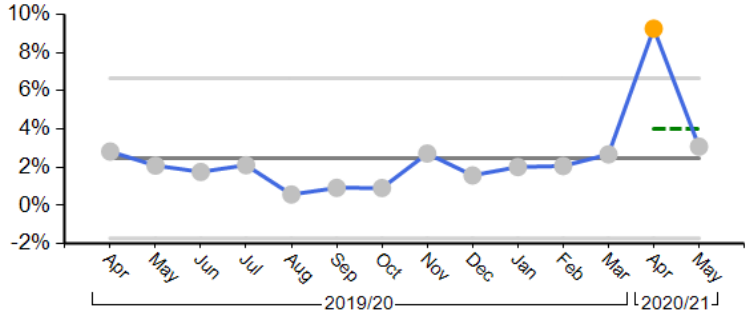
Sickness Rate (Rolling 12 Month)

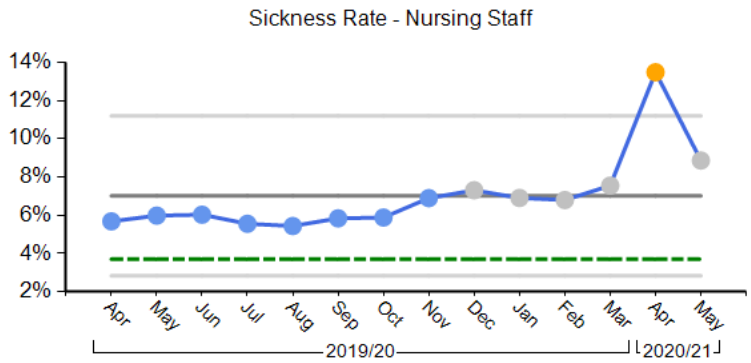


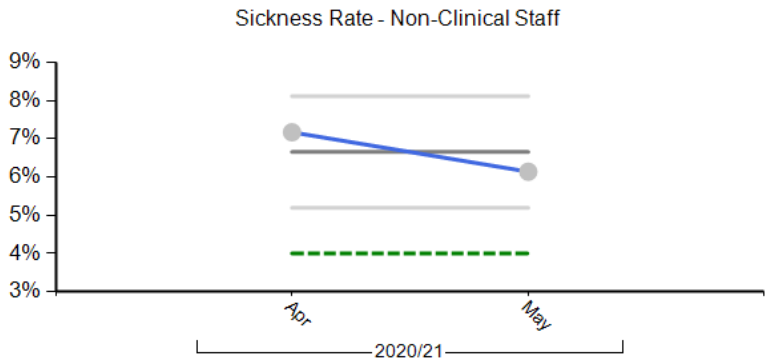
Time to Recruit



Sickness Rate - Medical Staff




Sickness Rate - Nursing Staff
14%
12%
10%
8%
6%
4%
2%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2019/20
2020/21


Sickness Rate - Non-Clinical Staff
9%
8%
7%
6%
5%
4%
3%
Apr
May
2020/21

Ward Dashboard Matrix

Southport and Ormskirk Hospital NHS Trust

	May 20	Planned Care									Specialist Services			Urgent Care													
		10B SSS/SAU	11A Gen Surg	14A	E - Gynae Surg	F Ward	G - Elective Ortho	H - Ortho Rehab	MFU	SIU	Maternity	NNU	Paeds	11B	14B	15A	15B Stroke Unit	7A	7B Rehab	9B	A/E	ACU	Critical Care	EAU	MDU	OBS	SSU
Governance	RM - Number of Patient Safety Incidents - Moderate / Major / Death (Related)	1	0	0	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	1	0		1	0	0	0	1
	RM - Total Number of Incidents	14	13	18	2	0	4	2	0	14	47	10	15	18	19	28	14	18	28	18	112		33	30	2	13	42
Harm Free Care	Patient Falls	3	3	1	0	0	1	0	0	5	1	0	0	4	5	8	0	0	8	3	2		0	0	0	0	10
	Pressure Ulcers Grade 2	0	1	2	0		0	0		0	0	0	0	1	1	1	0	1	0	1	0	0	0	0	0	0	0
	Pressure Ulcers Grade 3	0	0	0	0		0	0		1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
	Pressure Ulcers Grade 4	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Realtime Staffing - Non Registered (Day)	88.5%	85.9%	94%	66.7%		85.3%	77.3%		103.5%	125.2%	69%	55.9%	97%	96.1%	105.7%	85%	96%	81.2%	106.1%	94.8%	38.8%	111.8%	93.5%		96.7%	106%
	Realtime Staffing - Non Registered (Night)	90.5%	105.6%	81.8%	87.2%		90.4%	75.6%		98.8%	108.7%	5.6%	54.8%	90.1%	86.9%	88.8%	76.7%	73.4%	67.6%	119.7%	63%	N/A	70.5%	82.1%		90.7%	87.4%
	Realtime Staffing - Registered (Day)	95.2%	83.8%	86.8%	76.4%		64.5%	59.7%		95.3%	96.9%	99.7%	85.7%	88%	99.7%	90.5%	69.5%	112.1%	90.9%	78.9%	77.7%	38.8%	71.4%	80.7%		93.5%	91.6%
	Realtime Staffing - Registered (Night)	98.6%	100.1%	97.4%	100.2%		50.5%	79.1%		100.5%	99.8%	99%	69.4%	94.6%	99.8%	99.5%	75.7%	153.3%	93.8%	99%	96.5%	N/A	91.4%	98.5%		88.5%	104.9%
	Safety Thermometer - Percentage of Patients With Harm Free Care	NTR	NTR	NTR	NTR		NTR	NTR		NTR	NTR			NTR	NTR	NTR	NTR	NTR	NTR	NTR			NTR	NTR		NTR	NTR
	VTE Prophylaxis Assessment	94.1%	85.7%	92.3%	NTR	97.1%	100%	NTR	100%	0%	98.3%			97.7%	95.2%	94.2%	97%	100%	76.2%	81.8%			88.9%	94.1%	100%	57.1%	100%
IPC	IC - Cases of C.Diff	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	1	0		0	0	0	0	1
	IC - Hand Hygiene Compliance	100%	NTR	NTR	NTR	NTR	NTR	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	NTR	100%	NTR	100%
	IC - Incidence of MSSA	0	0	0	0		0	0		1	0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
	IC - MRSA Bacteraemias	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
Patient Experience	FFT Responses as % of Discharges	NTR	NTR	NTR	NTR	39.3%	NTR	NTR	80%	NTR	NTR	NTR	21.8%	NTR	NTR	NTR	NTR	NTR	NTR	NTR	35.2%			NTR	19.9%	NTR	NTR
	Friends & Family - % That Would Recommend	NTR	NTR	NTR	NTR	100%	NTR	NTR	100%	NTR	NTR	NTR	97.4%	NTR	NTR	NTR	NTR	NTR	NTR	NTR	94.8%			NTR	100%	NTR	NTR
	Number of Complaints	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1		1	0	0	0	1
Staff Development	HR - Mandatory Training	87.74%	81.36%	77.03%	NTR	95%	NTR	NTR	91.67%	84.84%	88.63%	86.79%	92.86%	80.3%	80.66%	94.8%	81.72%	78%	95.22%	93.05%	86.31%		86.9%	93.62%	88.2%	87.77%	85.62%
	HR - Personal Development Reviews	91.3%	55.2%	51.6%	81%	33.3%	90.9%	44.4%	100%	52.5%	64%	84.6%	84.2%	63.3%	88.2%	69.2%	37.9%	55.6%	83.3%	70.8%	77%		80.8%	74.2%	75%	72.7%	70%

Staffing and Workforce	HR - Sickness Absence Rate	7.78%	24.47%	11.25%	7.32%	20.11%	8.27%		8.31%	9.72%	4.66%	6.3%	4.22%	8.56%	16.02%	7.69%	10.93%	7.57%	18.09%	5.26%	8.39%		4.07%	7.79%	2.57%	5.68%	11.06%
	HR - Staff Turnover	3.51%	0%	4.35%	0%	0%	0%	0%	0%	1.04%	0%	3.45%	1.16%	0%	0%	0%	0%	0%	0%	2.99%	0%		1.39%	0%	0%	0%	2.56%
	Realtime Staffing - Staffing against Minimum Compliance	92.7%	90.2%	90%	80.5%		70.8%	72.2%		99.6%	104.3%	87.6%	69.3%	92.7%	96.4%	97.2%	77.6%	107.3%	84%	97.8%	85.9%	38.8%	82%	88.2%	N/A	91.9%	97.9%

Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**01 JULY 2020**
Agenda Item	**TB 113/20**	**FOI Exempt**	**No**
Report Title	**FINANCE REPORT – MONTH 2 2020/21**		
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides the Board with the financial position for month 2 2020/21.

Executive Summary

Due to COVID-19 the Trust is operating within a revised financial framework and for the first four months of the financial year all Trusts will break-even due to a "top up" fund provided by NHSE/I and additional funding for COVID-19.

The financial framework is being revised for the period 1 August 2020 to 31 March 2021 with further guidance expected in the week commencing 29 June 2020.

The Trust delivered a break-even position in month 2 but, as in April, did not require the full top up (excluding COVID-19) in order to do this.

The Month 2 top up value required was £606,000 higher than month 1 reflecting a higher financial impact from COVID-19 (£116,000) together with higher expenditure and lower income (combined £490,000).

COVID-19 expenditure was £1,045,000 in May 2020 (£2,035,000 year to date)

The Trust is underspending against the expenditure plan set by NHSE/I as non COVID-19 activity is significantly down in areas such as elective surgery and outpatients. This is having an impact, particularly in non pay. The Trust has a healthy cash balance at the end of May. In summary the Trust has operated within the financial target set by NHSE/I in the first two months of the financial year.

Recommendation

The Board is asked to receive the Finance Report – Month 2 2020/21

Previously Considered By:

✓ **Finance, Performance & Investment Committee**

Strategic Objectives

✓ **SO3** Efficiently and productively provide care within agreed financial limits

Prepared By:	**Presented By:**
Kevin Walsh	Steve Shanahan

Finance Report – Month 2 2020/21

1. Purpose

1.1. This report provides the Board with the financial position for month 2 2020/21.

2. Executive Summary

2.1. Due to COVID-19 the Trust is operating within a revised financial framework.

2.2. For the first four months of the financial year all Trusts will break-even due to a "top up" fund provided by NHSE/I and additional funding for COVID-19.

2.3. The financial framework is being revised and will also now cover the period August 1st 2020 to 31st March 2021.

2.4. The Trust delivered a break-even position in month 2 and did not require the full top up (excluding COVID-19).

2.5. The Month 2 top up value required was £606,000 higher than month 1 reflecting other income and expenditure pressures.

2.6. This includes an increase of £116,000 to pay for the impact of COVID-19.

2.7. In addition to the impact of COVID-19 the expenditure run rate also increased by £248,000 compared to April.

2.8. The balance relates to income pressures in May of £242,000

2.9. Due to the current focus on COVID-19 activity both pay and non-pay budgets have continued to underspend due to the significant activity reduction in other areas of the hospital (elective, outpatients, A&E and other non-elective work) although this underspend did reduce in May.

3. There are no cash issues as a result of the schedule of income payment within the current financial arrangements.

4. Income and Expenditure

4.1. NHSE/I set the Trust's I&E Plan for the first four months of the year based on average of months 8, 9 and 10 expenditure.

4.2. An adjustment for both pay and non pay inflation was also included.

4.3. The NHSE/I plan excluded any financial impact of COVID-19.

4.4. The Trust set the opening annual budget based on the NHSE/I plan.

4.5. The month 2 year to date (YTD) budget has been adjusted for:

- Non-recurrent issues that impacted on months 8, 9 and 10.
- Previously agreed business cases that will impact in 2020/21 eg H Ward.
- Financial impact of COVID-19 in both April and May.

4.6. A budget has been set each month for the expenditure impact of COVID-19 (YTD £2.035

million) so none of the expenditure budget variance to date relates to COVID-19.

4.7. The NHSE/I plan was adjusted in the Trust's opening budget to fund the actual CNST premium. The premium has now been reduced by £412,000. This relates to 10% of the maternity premium which was to be earned as a CIP schemes. The CNST expenditure budget has been adjusted down in month 2.

4.8. A budget has been set for Ward H (Ormskirk rehabilitation ward) which should be funded from the top up as 2020/21 service developments were not included in NHSE/I's calculation of the top up.

4.9. The NHSE/I income top up was forecast to be £2.785 million for May (£5.570 million YTD).

4.10. The actual top up before the impact of COVID-19 was £2.396 million for May (£4.302 million YTD).

4.11. The lower top up request was due to the under-spend on expenditure budgets net against lower income.

4.12. The following table demonstrates the top up requirement and the increase in funding requested from NHSE/I between months 1 and 2:

	Month 1 £000	Month 2 £000	Notes
NHSE/I Top-up (A)	2,785	2,785	
Under spend on NHSE/I set expenditure budgets	(879)	(631)	Non COVID-19 Expenditure increased by £248k; Pay increased by £450k however Non pay reduced by a further £202k
Decrease in other income assumed in the top-up as recurrent that has not materialised in 2020/21		124	£124k + £118k totals £242k which reconciles to £242k commissioning income adv variance on finance report I&E
2019/20 NCA income not received		118	
COVID-19 expenditure	990	1,045	
COVID-19 income	203	264	
Top–up Required (B)	3,099	3,705	
Top Up adjustment (B less A)	314	920	
Increase from Month 1		606	

4.13. The additional £606,000 top up requirement is further broken down as follows:

Total funding requested increase Month 1 to Month 2	**606**
Additional funding requested in month 2 required due to:	
Pay costs increased by	(450)
Non pay costs decreased by	202
COVID_19 costs increased by	(55)
COVID_19 income decreased by	(61)
2019/20 income issue (NCA)	(118)
Other income decreased by	(124)
Total	**(606)**

4.14. The table below is the I&E statement for month 2 2020/21:

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	171,559	30,282	30,040	(242)	12,096	12,798	702
PP, Overseas & RTA	748	125	67	(58)	62	38	(25)
Other Income	11,851	2,027	1,576	(451)	994	773	(221)
NHSE/I Top Up	37,330	6,222	4,769	(1,453)	6,222	4,769	(1,453)
Total Operating Income	**221,487**	**38,655**	**36,452**	(2,203)	**19,374**	**18,378**	(996)
PAY	(151,134)	(26,357)	(25,560)	797	(13,190)	(13,002)	188
NON PAY	(57,763)	(10,200)	(8,858)	1,342	(5,066)	(4,325)	741
Total Operating Expenditure	**(208,897)**	**(36,557)**	**(34,418)**	**2,139**	**(18,256)**	**(17,327)**	**929**
EBITDA	**12,590**	**2,098**	**2,034**	**(64)**	**1,118**	**1,050**	**(67)**
Net Financing Costs	(12,590)	(2,098)	(2,059)	39	(1,118)	(1,063)	55
Retained Surplus/Deficit	**0**	**0**	**(25)**	**(25)**	**0**	**(13)**	**(12)**
Technical Adjustments	0	0	25	25	0	12	12
Break Even Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4.15. The favourable expenditure variances in the above table demonstrate that the Trust is underspending against the NHSE/I plan (with adjustments described in sections 4.4 - 4.8).

5. COVID-19

5.1. The Trust's 2020/21 opening budget excluded any income or expenditure relating to COVID-19 as this will fluctuate month to month and was not included in the plan figures provided by NHSE/I.

5.2. Each month, the COVID-19 financial impact is calculated and submitted to NHSE/I for approval and payment.

5.3. The table below identifies the financial impact for both April and May 2020:

	Pay £000	Non Pay £000	Total Exp £000	Income Top Up £000	Income COVID-19 £000
Month 1	(696)	(294)	(990)	203	990
Month 2	(715)	(330)	(1,045)	264	1,045
Variance	(19)	(36)	(55)	61	55
Month 2 YTD	(1,411)	(624)	(2,035)	467	2,035

5.4. The majority of the YTD pay spend is within medical (£500,000) and nursing (£677,000) staff. Within non pay the key areas are cleaning equipment and protective clothing (£250,000) and medical & surgical equipment (£170,000)

5.5. In month 2 a YTD budget of £2,035,000 has been set on both income and expenditure to reflect the additional income to be funded from NHSE/I in respect of pay and non pay expenditure.

5.6. A budget for those areas where £467,000 income has been lost YTD (car park, catering, RTA, private patients etc) has already been set in the 2020/21 base budget so no budget adjustments have been made relating to lost income. This will be reimbursed by NHSE/I as part of the top up.

5.7. The above financial arrangement will continue throughout 2020/21 and income will be accrued on a monthly basis in order to mitigate the financial impact of COVID-19.

5.8. NHSE/I will be auditing a number of trusts whose top up request has increased significantly as a result of the new financial framework. There is no indication that the Trust will be part of this review.

6. Expenditure

6.1. Please refer to the attached appendices for more detailed information regarding expenditure and Whole Time Equivalent (WTE) run rate.

6.2. Although expenditure is underspent against budget the expenditure run rate has increased by £303,000 compared to April.

6.3. Of this figure £55,000 relates to increased COVID-19 spend which is covered within section 4. The remaining £248,000 is a combination of higher pay costs (£450,000), lower non pay costs (£270,000) and higher non operating expenditure (£68,000).

6.4. The main run rate increase within pay is the two Easter bank holidays which attract enhancements in May accounting for £128,000 of the increase.

6.5. The largest increase in pay spend is within Nursing & Midwifery (£300,000 excluding COVID-19 which has seen a reduction of £41,000).

6.6. The increase in mainly within Urgent Care across all medical wards and A&E

6.7. Early recruitment of student nurses to assist with COVID-19 has impacted in May (£74,000) although the bank and agency figures don't support the assumption that these staff would fill vacancies at band 3 and 4 and, therefore, reduce the requirement for premium spend.

6.8. The Year 3 students have been given a 6 month contract and are being paid at band 4 which results in an overestablishment.

6.9. Any students part-way through their degree have been placed into band 3 roles on 12 week contracts.

6.10. The impact of reconfiguring services for COVID-19 continues to have a material impact within non pay where a number of budgets associated with elective activity are underspending.

6.11. As the elective programme is restarted non pay expenditure is expected to rise.

6.12. The CNST premium has reduced in May accounting for £69,000 of the run rate reduction in non pay.

6.13. Drug spend is also low as a result of less MDU activity taking place.

6.14. Non Operating Expenditure has increased due to the PDC Dividend being matched to budget (as per the NHSE/I plan).

6.15. This will be revisited as further guidance regarding the actual PDC dividend payment is issued.

7. Bank and Agency spend

7.1. Bank and agency spend has risen back up to March levels.

7.2. Monthly agency spend in April has increased to £1.115 million (8.6% of the pay bill); Medical staff £521,000 (month 1 £565,000); Nursing £492,000 (month 1 £358,000). This includes

agency spend of £214,000 on COVID-19 (£158,000 in April).

7.3. Monthly bank spend in May is similar to April at £1.189 million (9.1% of the total pay bill). This includes bank spend of £346,000 on COVID-19.

7.4. The Trust has spent £2.303 million on bank and agency staff in month 1 (17.7% of the pay bill). However, £570,000 of this was on COVID-19 (April £578,000).

8. Income and Activity Performance

8.1. There is no monitoring of Trust activity during the first four months due to the financial framework in place which has impacted on elective, outpatient and A&E activity levels.

8.2. Total income consists of block contracts, NHSE/I "top up", COVID-19 funding and all other income.

8.3. As in month 1 a lower income figure was required than budget due to lower levels of expenditure.

8.4. Within commissioning income £118,000 of the £242,000 YTD figure relates to non contracted activity (NCA) income accrued in 2019/20 which has not materialised. This is partially due to the impact of COVID-19 in March.

8.5. The remaining commissioning income shortfall relates to errors in the calculation used by NHSE/I in assessing the Trust's commissioning income. As the Trust is able to apply for top up funding to break-even this is not currently an issue.

8.6. Road Traffic Accident (RTA), catering and car park income are the other main adverse variances on income. The shortfall is mitigated by the top up funding as highlighted in the COVID-19 return in the appendices.

9. Cost Improvement Plan (CIP) Performance

9.1. The Trust is not required to make any savings in the first four months of the year although the existing programme is currently being refreshed in readiness for when further savings will be required.

10. Cash

10.1. To support cash flow NHS providers have been moved onto block contracts together with block funding which is coming from Clinical Commissioning Groups (CCGs) and NHS England.

10.2. In addition the timetable for the first four months is that providers receive contract income a month in advance.

10.3. For example, in mid-June the Trust received July's funding.

10.4. It is anticipated that this arrangement will continue for the whole financial year.

10.5. As a result of this arrangement the Trust had a healthy cash balance at the end of May of £16.183 million.

11. Debtors

11.1. Overall debt has Increased to £7.6 million from £6.4 million last month

11.2. This is split with an increase in NHS debt of £1.6 million and a decrease in non NHS debt of

£0.4 million.

11.3. The driver on NHS debt is the raising of over-performance invoices for 2019/20 to the Trust's main commissioners.

11.4. There's been significant progress on NHS Property Services debt as the Trust received a substantial payment in May this reduced the debt from £670,000 last month to £84,000 in May 2020.

11.5. In line with the cash arrangements, the Trust is no longer billing CCGs or NHS England so no adjustments are required for sales invoices raised in advance.

12. Capital

12.1. A high-level year to date and forecast outturn capital performance is shown in the appendices.

12.2. The main spending has been on COVID-19, IT, smaller amounts on medical equipment and Estates (car parking system).

12.3. Note the Trust was required to submit details to NHSE/I for both COVID-19 phase 1 (orders up to 18th May) and phase 2 (schemes that require regional/national approval).

12.4. Phase 2 proposals include: Emergency Care reorganisation (£1.6m); Elective surgery support (£650,000) covering Ormskirk Theatre recovery and Endoscopy); Diagnostic (second CT scanner, Southport site, £550,000); Paediatric A&E (£200,000); IT required for agile working (£469,000) and Corporate Management Offices changes to become COVID secure (£148,000).

13. Recommendations

13.1. The Board is asked to receive the Finance Report – Month 2 2020/21.

List of Appendices

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

1. Expenditure run rate by month - £000

Class	STAFF GROUP	STAFF TYPE	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	COVID May-20	excl COVID May-20
PAY	Consultants	Substantive	(1,239)	(1,234)	(1,321)	(1,235)	(1,396)	(1,282)	(1,267)	(1,246)	(1,244)	(1,224)	(1,619)	(1,285)	(1,319)	*(14)*	*(1,305)*
		Bank	(70)	(65)	(112)	(65)	(75)	(84)	(80)	(77)	(40)	(94)	(107)	(86)	(85)	*(45)*	*(40)*
		Agency	(279)	(201)	(275)	(266)	(341)	(264)	(290)	(363)	(314)	(263)	(282)	(258)	(270)	*(35)*	*(235)*
	Consultants Total		(1,587)	(1,500)	(1,708)	(1,566)	(1,812)	(1,630)	(1,636)	(1,686)	(1,598)	(1,581)	(2,009)	(1,629)	(1,673)	*(93)*	*(1,580)*
	Other Medical	Substantive	(1,285)	(1,304)	(1,277)	(1,293)	(1,409)	(1,308)	(1,256)	(1,274)	(1,261)	(1,261)	(1,353)	(1,379)	(1,379)	*0*	*(1,379)*
		Bank	(167)	(195)	(155)	(174)	(171)	(146)	(182)	(139)	(151)	(184)	(211)	(214)	(310)	*(93)*	*(217)*
		Agency	(257)	(277)	(288)	(255)	(235)	(247)	(258)	(304)	(279)	(272)	(296)	(307)	(251)	*(70)*	*(181)*
	Other Medical Total		(1,709)	(1,776)	(1,720)	(1,722)	(1,815)	(1,701)	(1,696)	(1,717)	(1,691)	(1,717)	(1,860)	(1,900)	(1,940)	*(164)*	*(1,777)*
	Nurses & Midwives	Substantive	(3,818)	(3,797)	(3,745)	(3,722)	(3,771)	(3,749)	(3,820)	(3,769)	(3,816)	(3,780)	(3,878)	(3,938)	(4,152)	*(41)*	*(4,111)*
		Bank	(637)	(645)	(632)	(671)	(656)	(684)	(665)	(669)	(696)	(721)	(809)	(835)	(748)	*(193)*	*(555)*
		Agency	(397)	(319)	(303)	(400)	(370)	(458)	(455)	(549)	(608)	(588)	(536)	(358)	(492)	*(84)*	*(407)*
	Nurses & Midwives Total		(4,852)	(4,761)	(4,680)	(4,793)	(4,796)	(4,891)	(4,941)	(4,987)	(5,119)	(5,089)	(5,224)	(5,132)	(5,391)	*(318)*	*(5,073)*
	Scientific, Technical & Therapeutic	Substantive	(1,370)	(1,351)	(1,343)	(1,369)	(1,394)	(1,404)	(1,420)	(1,416)	(1,364)	(1,379)	(1,360)	(1,373)	(1,438)	*(8)*	*(1,430)*
		Bank	(7)	(7)	(8)	(6)	(5)	(5)	(4)	(12)	(10)	(12)	(7)	(9)	(12)	*(4)*	*(8)*
		Agency	(8)	(20)	(35)	(26)	(72)	(28)	(39)	(38)	7	(38)	(42)	(41)	(43)	*0*	*(43)*
	Scientific, Technical & Therapeutic Total		(1,384)	(1,378)	(1,386)	(1,400)	(1,471)	(1,437)	(1,463)	(1,466)	(1,367)	(1,429)	(1,409)	(1,424)	(1,493)	*(12)*	*(1,481)*
	Other Staff	Substantive	(2,156)	(2,147)	(2,090)	(2,115)	(2,150)	(2,120)	(2,126)	(2,128)	(2,190)	(2,177)	(2,168)	(2,348)	(2,384)	*(93)*	*(2,291)*
		Bank	(17)	(27)	(34)	(40)	(28)	(24)	(26)	(23)	(25)	(27)	(22)	(29)	(33)	*(11)*	*(22)*
		Agency	(54)	(48)	(64)	(78)	(34)	(112)	(87)	(80)	(42)	(64)	(17)	(35)	(60)	*(24)*	*(35)*
	Other Staff Total		(2,227)	(2,223)	(2,188)	(2,232)	(2,213)	(2,256)	(2,239)	(2,231)	(2,257)	(2,268)	(2,207)	(2,412)	(2,477)	*(129)*	*(2,348)*
	Pay Reserves	Substantive	(56)	149	(191)	(54)	914	(0)	0	501	(0)	(0)	(1,207)	(4)	4	*0*	*4*
	Pay Reserves Total		(56)	149	(191)	(54)	914	(0)	0	501	(0)	(0)	(1,207)	(4)	4	*0*	*4*
	Pay CIP	Substantive	0	0	0	0	0	0	0	0	0	0	0			*0*	*0*
	Pay CIP Total		0	0	0	0	0	0	0	0	0	0	0			*0*	*0*
	Apprenticeship Levy	Substantive	(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)	(43)	(40)	(46)	(45)	(44)	*0*	*(44)*
	Apprenticeship Levy Total		(42)	(38)	(50)	(36)	(43)	(46)	(39)	(46)	(43)	(40)	(46)	(45)	(44)	*0*	*(44)*
PAY Total			(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)	(12,075)	(12,124)	(13,962)	(12,545)	(13,014)	*(715)*	*(12,299)*
NON-PAY	Supplies & Services Clinical		(2,325)	(2,259)	(2,420)	(2,264)	(2,227)	(2,382)	(2,299)	(2,334)	(2,481)	(2,380)	(2,376)	(2,035)	(1,846)	(28)	*(1,818)*
	Supplies & Services General		(172)	(173)	(164)	(189)	(219)	(211)	(191)	(204)	(203)	(191)	(306)	(261)	(363)	(224)	*(139)*
	Non-Executive Directors		(6)	(6)	(8)	(4)	(6)	(6)	(10)	(6)	(6)	(7)	(8)	(9)	(9)	0	*(9)*
	Establishment Expenses		(226)	(232)	(221)	(245)	(242)	(237)	(231)	(249)	(214)	(204)	(210)	(199)	(223)	(29)	*(194)*
	Premises & Fixed Plant		(1,035)	(991)	(985)	(1,055)	(948)	(1,061)	(1,132)	(1,109)	(1,109)	(1,127)	(1,135)	(1,072)	(1,038)	(46)	*(992)*
	Miscellaneous		(720)	(716)	(735)	(717)	(666)	(740)	(723)	(460)	(705)	(684)	(684)	(806)	(749)	(3)	*(746)*
	Services From Other NHS Bodies		(61)	(69)	(145)	(188)	(136)	(137)	(106)	(114)	(100)	(149)	(53)	(141)	(87)	0	*(87)*
	Non Pay Reserve		7	0	0	0	0	0	0	0	0	0	0	(10)	(10)	0	*(10)*
	Non Pay CIP		0	0	0	0	0	0	0	0	0	0	0			0	*0*
NON-PAY Total			(4,538)	(4,446)	(4,678)	(4,662)	(4,443)	(4,775)	(4,692)	(4,477)	(4,818)	(4,743)	(4,773)	(4,533)	(4,325)	*(330)*	*(3,995)*

PAY	Substantive	(9,964)	(9,723)	(10,016)	(9,822)	(9,248)	(9,908)	(9,928)	(9,378)	(9,917)	(9,861)	(11,633)	(10,372)	(10,711)	*(156)*	*(10,555)*
	Bank	(898)	(940)	(942)	(956)	(936)	(944)	(956)	(920)	(922)	(1,037)	(1,157)	(1,174)	(1,189)	*(346)*	*(843)*
	Agency	(995)	(864)	(966)	(1,024)	(1,050)	(1,109)	(1,129)	(1,334)	(1,236)	(1,225)	(1,173)	(999)	(1,115)	*(214)*	*(901)*
PAY Total		(11,857)	(11,527)	(11,924)	(11,803)	(11,235)	(11,961)	(12,014)	(11,632)	(12,075)	(12,124)	(13,962)	(12,545)	(13,014)	*(715)*	*(12,299)*

2. WTE run rate worked by month

STAFF GROUP	STAFF TYPE	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	COVID May-20	excl. COVID May-20
Consultants	Substantive	95	94	94	95	95	95	95	97	95	98	100	103	101	1	100
	Bank	5	3	5	3	3	4	5	4	1	5	10	7	5	2	2
	Agency	12	9	12	12	13	14	13	13	14	13	12	11	11	1	10
Consultants Total		111	106	111	110	111	113	114	115	110	117	122	121	117	5	112
Other Medical	Substantive	221	212	223	220	212	211	208	213	212	207	223	228	232		232
	Bank	11	9	12	12	9	12	16	12	5	17	16	37	22	9	14
	Agency	23	24	22	20	20	21	23	22	22	23	22	24	19	6	12
Other Medical Total		255	245	258	252	241	244	248	247	239	246	260	289	273	15	258
Nurses & Midwives	Substantive	1,121	1,110	1,109	1,107	1,102	1,121	1,142	1,124	1,148	1,158	1,168	1,166	1,227	11	1,216
	Bank	185	186	189	196	187	197	199	194	203	205	231	207	170	35	135
	Agency	60	54	57	66	65	75	84	91	105	106	94	64	79	13	66
Nurses & Midwives Total		1,367	1,350	1,355	1,369	1,354	1,394	1,425	1,409	1,457	1,469	1,493	1,437	1,476	59	1,417
Scientific, Technical & Therapeutic	Substantive	405	392	400	405	413	411	413	412	409	412	407	402	408	1	407
	Bank	2	1	2	2	1	1	2	2	2	2	2	3	3	1	2
	Agency	1	4	6	5	6	5	5	5	6	5	5	5	6		6
Scientific, Technical & Therapeutic Total		408	397	408	412	420	417	421	419	417	420	414	411	417	2	415
Other Staff	Substantive	802	805	797	803	804	824	818	810	816	819	844	841	848	19	828
	Bank	13	10	14	14	13	12	12	12	11	12	10	15	11	1	10
	Agency	10	13	10	12	9	11	10	10	5	9	7	4	14	10	4
Other Staff Total		825	828	821	829	826	848	839	833	832	840	861	860	872	30	842
Pay Reserves	Substantive	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pay Reserves Total		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Grand Total		**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**	**3,047**	**3,023**	**3,054**	**3,092**	**3,151**	**3,117**	**3,155**	**111**	**3,044**

	Substantive	2,643	2,613	2,623	2,630	2,626	2,663	2,677	2,657	2,680	2,694	2,741	2,741	2,815	32	2,783
	Bank	215	210	222	227	213	226	234	225	223	241	269	269	211	48	163
	Agency	108	103	107	115	113	126	135	142	152	156	140	108	129	31	98
Grand Total		**2,966**	**2,926**	**2,952**	**2,972**	**2,952**	**3,015**	**3,047**	**3,023**	**3,054**	**3,092**	**3,151**	**3,117**	**3,155**	**111**	**3,044**

3. Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2020	31/05/2020		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	108,562	108,938	376	(152)
Other assets	1,075	1,271	196	63
TOTAL NON CURRENT ASSETS	**109,637**	**110,209**	**572**	**(89)**
CURRENT ASSETS				
Inventories	2,469	2,556	87	(20)
Trade and other receivables	13,282	15,261	1,979	3,046
Cash and cash equivalents	1,067	16,153	15,086	283
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**16,818**	**33,970**	**17,152**	**3,309**
CURRENT LIABILITIES				
Trade and other payables	(21,761)	(23,318)	(1,557)	13,436
Provisions	(536)	(467)	69	0
PFI/Finance lease liabilities	(1,137)	(1,137)	0	0
DHSC revenue loans	(130,260)	(130,267)	(7)	(660)
DHSC Capital loan	(1,342)	(1,335)	7	0
Other liabilities	(1,212)	(17,691)	(16,479)	(16,074)
TOTAL CURRENT LIABILITIES	**(156,248)**	**(174,215)**	**(17,967)**	**(3,298)**
NET CURRENT ASSETS/(LIABILITIES)	(139,430)	(140,245)	(815)	**11**
TOTAL ASSETS LESS CURRENT LIABILITIES	**(29,793)**	**(30,036)**	**(243)**	**(78)**
NON CURRENT LIABILITIES				
Provisions	(152)	(239)	(87)	0
DHSC revenue loans	0		0	0
PFI/Finance lease liabilities	(12,606)	(12,501)	105	53
DH Capital loan	(600)	(400)	200	0
TOTAL NON CURRENT LIABILITIES	**(13,358)**	**(13,140)**	**218**	**53**
TOTAL ASSETS EMPLOYED	**(43,151)**	**(43,176)**	**(25)**	**(25)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	99,965	99,965	0	0
Retained earnings	(149,036)	(149,061)	(25)	(25)
Revaluation reserve	5,920	5,920	0	0
TOTAL TAXPAYERS EQUITY	**(43,151)**	**(43,176)**	**(25)**	**(25)**

4. Capital Expenditure

Capital scheme	May-20 YTD £'000s	20/21 FOT £'000s
Medical equipment	117	200
Pharmacy Relocation		150
Pharmacy Robots		250
IT schemes	516	1,597
Estates schemes - backlog	133	2,216
Estates schemes - non backlog		100
Catering equipment		25
Donated asset; equipment		100
Veolia Energy Centre contract - boiler change		1
GE Radiology equipment replacement programme (IFRIC 12)		710
Covid-19 phase 1	718	957
Covid-19 phase 2		3,617
	1,484	**9,923**

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 23 June 2020
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Personal Development Reviews (PDR)
PDR compliance is now at 67.02% for May 2020 which is a decrease from 69.10% in April 2020. In addition, according to the Integrated Performance Report this data, despite the decrease, has a neutral variation. It was agreed for PDRs to be one of the recommended areas of focus for a deep dive analysis.

NHSP Performance Contract
NHSP performance remains below the KPIs detailed in the contract; 59.64% of all shifts released through the roster were filled by bank workers, 26.79% were filled by agency workers and 13.57% were unfilled in May 2020; however KPIs require 67% bank fill and 18% agency fill at this stage of the contract. This remains a concern and the contract will now be subject to performance management.

ADVISE

Safe Staffing
For the month of May 2020 the Trust reports safe staffing against the national average (90%) at 90.15% showing an improved overall fill rate from the previous month. There was discussion by the Committee over some discrepancies in the report. It was agreed that further assurance was required as the data cleanse completes. The Bi-Annual Safe Staffing report was additionally discussed and received.

Medical Vacancy Rate
The medical vacancy rate for the month of May 2020 is 15.6% against the target of 5%. However this increase is reflective of an error in reporting (bank and agency has previously been included in the report in addition to substantive staff). Overall, following recruitment activity we should see a net 'no change'.

Core Mandatory Training
Compliance for Core Mandatory Training has slightly increased in month to 87.12% from 87.09%, despite the error within the Dashboard detailing the April 2020 rate as 87.67% in April 2020.

Clinical Training
The risk regarding clinical training was discussed. The Head of Education, Training and OD informed the membership that it will be discussed at great length in process mapping meetings by key stakeholders to ensure clarity of the risk and appropriate mitigation. This is an imminent piece of work and the Chair advised that the Quality and Safety Committee are the primary Committee for this risk with Workforce monitoring it.

Board Assurance Framework (BAF)
It was noted that the SO5 document included in the boardpack of papers was the incorrect version. The Chair highlighted disappointment and concern over the structure and composition of the BAF documentation and apologies were expressed to the Chair and membership. The Committee agreed for the draft BAF to be submitted to the Board subject

to the agreement of the membership.

Staff Turnover
The staff turnover rate in 12 months has decreased to 12.31% in month from 12.61% in April 2020. Whilst there has been a decrease in month, there has been improvement achieved in retention rates whereby benchmark data shows the Trust is performing better than the national and peer (clinical output) median at 87.4% compared to 86.7%. The Trust has its highest rates of leavers in the 26-30 age band and further improvement is required to have a clear retention approach in this and other staff groups.

Medical Sickness
There has been a negative variation for the sickness rates for medical staff: 9.2% in April 2020 and 2.9% in May 2020 against the target of 4%.

Medical dental workforce job planning, cost, implications and review
It was advised that 90 job plans out of 170 were completed and backdated to be effective from January 2020, with a £330,000 cost pressure spend due to increasing PAs as some medical staff weren't paid appropriately. It was agreed that a formal appeal process was required and that the job planning process needs a root and branch review

ASSURE

Time to Hire
The average Time to Hire in May 2020 was 51.11 days, from 52.57 days in April 2020, against the revised Trust target of 55 days. It was commented this reduction is very positive and the Committee formally congratulated the Recruitment Team in their efforts.

Sickness Absence
The monthly Sickness absence rate has decreased in month to 7.01% from 10.23% in April 2020, whilst the rolling year to date sickness absence rate highlights that there has been a decrease in May 2020 to 5.40% from 5.70% in April 2020. The sickness absence rate for COVID-19 is 2.61%.

Staff Friends and Family
The Trust response rate for Quarter 4 has increased from 14% to 14.75% and thus results are statistically significant. There have been improvements in both questions: how likely are you to recommend the Trust as a place to work and how likely are you to recommend the Trust to friends and family if they needed care or treatment.

New Risk identified at the meeting	None.

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

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB115/20**	**FOI Exempt**	**No**
Report Title	**Bi Annual Staffing Establishment review**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Claire Harrington, Deputy Director of Nursing Carol Fowler, Assistant Director of Nursing Workforce		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides a comprehensive update on nurse and midwifery staffing, mainly focusing within the inpatient bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

Executive Summary

Overview

The Trust is required to complete and report bi-annual nurse staffing review activity. The purpose of this paper is to provide context of these reviews, actions taken, and also to provide broader context of Nursing and Midwifery staffing models, innovation and direction for the next 6 months. This report is the first following the initial review presented to Trust Board May 2019 concluding in an agreed uplift in nurse staffing of Registered nurse of 54.53 wte, HCA 59.28 wte and Ward Clerks 3.27 wte. This is reflected in rosters and is reflected in the Trust vacancy rate reported in this paper.

Key Points in this paper

- Urgent Care 104 band 5 (inpatient ward area) vacancies
- Planned Care 43 band 5 (inpatient ward area) vacancies
- Specialist services (inpatient ward areas) – 5 wte over funded establishment
- Strong performance in the recruitment to HCA vacancies
- Positive engagement and growth of advanced roles across the CBU's with further planned
- Positive engagement with apprenticeship opportunities with growth planned
- Realignment within current budgeted establishment to support development roles.
- Registered Nurse fill by agency is reducing

Actions and Next steps

- The report demonstrates that current recruitment plans are not significantly impacting on vacancy rate in medicine and surgery
- Therefore as part of the wider recruitment and retention plan, a step change is expected in the next 6 months to reduce the immediate, medium and long-term vacancy rate. This includes strategic partnership working with Universities, international recruitment 2020, growth by 50% of students in 2020/21 targeting local population, nurse apprenticeship roles using Levy.
- The Director of Nursing will become part of the regional work stream working with Health Education England to ensure Southport and Ormskirk is centric to developing workforce options regionally
- Allied Health Professional workforce will be included in future reporting as it is expected following the next staffing reviews that the clinical workforce will need to be reviewed as a whole to provide context and also to explore innovation and alternative roles

Recommendation

The Board is asked to receive the report and support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	☐ **Quality & Safety Committee** ✓ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
✓ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Claire Harrington, Deputy Director of Nursing Carol Fowler, Assistant Director of Nursing, Workforce	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance

Comprehensive Bi-Annual Nurse Staffing Paper

1. Purpose

This report provides the Board with a comprehensive update on nurse and midwifery staffing, mainly focusing within the bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

2. Background and Context

It is well recognised nationally, that the shortfall in registered nurses is one of the most urgent needs to address for all NHS providers. Improving the workforce shortages in nursing is one of the five specific workforce challenges outlined in the Interim NHS People Plan published in June 2019.

As a result of the covid-19 pandemic, we have had to manage a constantly changing workforce situation to ensure patient and staff safety. This is particularly apparent in April 2020 data which is skewed due to high levels of absence, decrease in numbers of inpatients and use of additional staff from other areas and professions e.g. therapies to fill roster gaps and ensure safe staffing.

3. Current Position

The charts (Table 1, Graph 1) provide a breakdown of our UNIFY fill rate data (November 2019 to April 2020 inclusive) collected and submitted externally on a monthly basis for our inpatient areas. It shows a percentage of the Planned v Actual staffing levels for both the Day and Night shifts split by registered and unregistered. The

During 2019-2020, through critical appraisal the Trust commenced a review of the data sources to support a single source of the truth to the workforce data reporting including UNIFY return.

In addition, we have worked on reviewing all the inpatient demand templates to ensure accuracy of reporting to consider all new and emerging roles (such as Assistant Practitioners (AP's), Nursing Associates (NA's), Advanced Nurse Practitioners (ANP/ACP's) etc.

Table 1- Percentage fill rate – Unify Submission Nov19-April 20

Month	Registered Day %	Unregistered Day %	Registered Night %	Unregistered Night %
Nov-19	91.09%	86.23%	95.13%	100.65%
Dec-19	89.82%	84.26%	93.77%	85.60%
Jan-20	90.73%	84.59%	97.73%	89.91%
Feb-20	88.76%	81.73%	94.16%	90.42%
Mar-20	85.07%	85.42%	96.59%	91.29%
Apr-20	80.13%	82.00%	85.05%	72.72%
Average	87.60%	84.04%	93.74%	88.43%

Graph 1- Nov 19 – April 20 Fill rates

4. Vacancies

Graph 2 below demonstrates that the Trust has seen 24wte Registered Nurse starters across this reporting period. The starters data is taken from ESR and vacancy from the finance ledger.

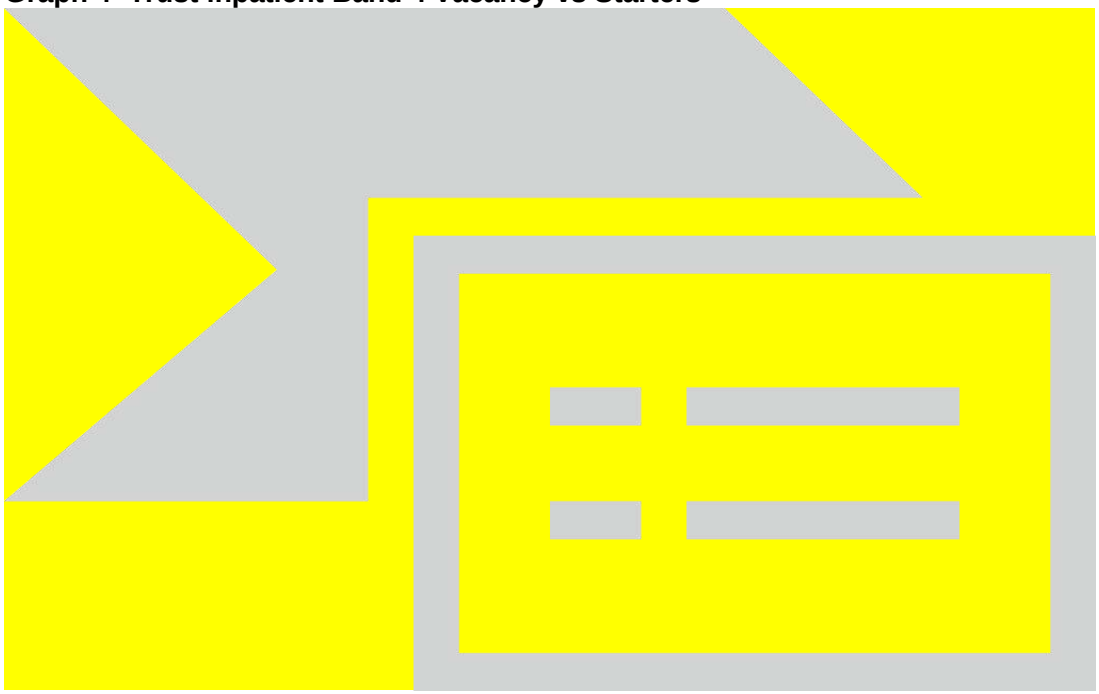
Graph 3 shows stronger performance against recruitment of HCA staff with 78.44wte starters across this reporting period. The starters data is taken from ESR and vacancy from the finance ledger.

Graph 4 reflects the response to the pandemic and the recruitment to the students into band 4 roles prior to their registration to the Nursing and Midwifery Council (NMC). The starters data is taken from ESR and vacancy from the finance ledger.

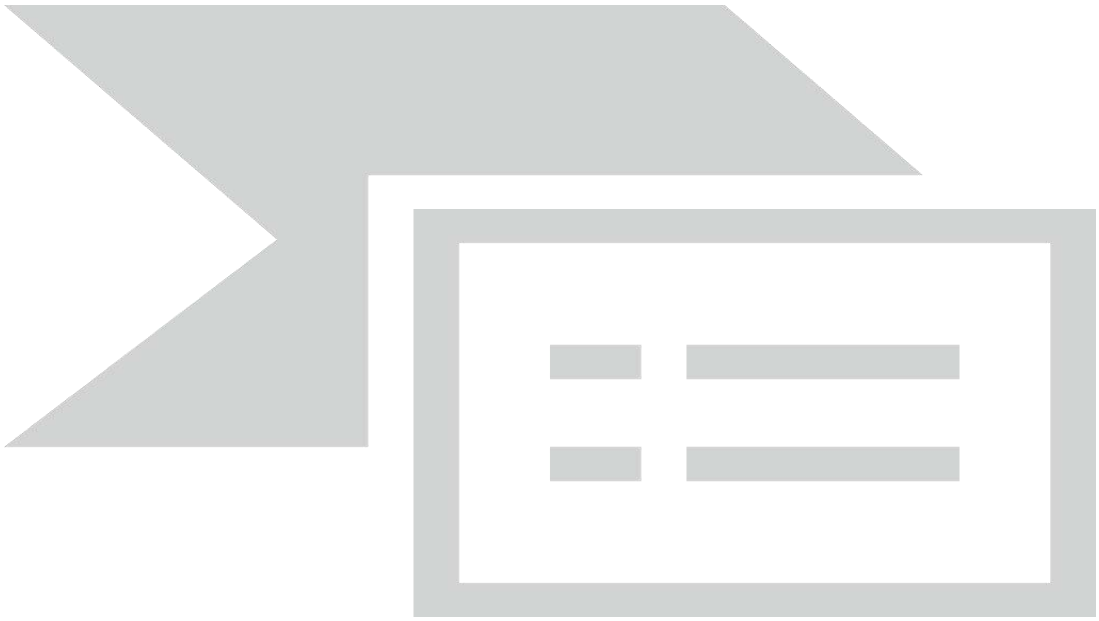
Graph 2 -Trust inpatient Band 5 Vacancy vs Starters

Graph 3 -Trust inpatient HCA Vacancy vs Starters

Graph 4 -Trust inpatient Band 4 Vacancy vs Starters



Graph 5 –Trust Band 5 nurses versus establishments



Graph 5 illustrates both the funded and contracted establishments for nurse band 5 nurses within inpatient areas between the period November 2019 to March 2021. From June 2020 onwards the contracted establishment has been predicted based on a number of assumptions including: turnover rate, student recruitment, retirees and international recruitment commencing in September 2020.

The predicted retirees figures included in the forecast above are based on actual retiree numbers between April 2019 – March 2020.

Table 2 –Predicted recruitment impact -Nurse Band 5 vacancies

Table 2 illustrates the predicted impact on nurse band 5 vacancies for inpatient areas over the following months. The turnover, recruitment and retirees figures are based on actual Trust figures from April 2019 – March 2020. International recruitment is set to commence in June with starters anticipated from September 2020 onwards. Due to the impact of COVID-19 the figures present an assumed position that there will be no retirees until September 2020.

Table 3-Trust age profile > 55yrs -Band 5 – inpatient areas

Ward	56-60	61-65	66-70	>=71 Years
F WARD SURGICAL DAYCASE ODGH	3			
G Ward (EL Orthopaedics)		1		
Emergency Assessment Unit	1			
FESS Ward				
ITU CCU	1	2		
Orthopaedic Rehab ward (H)	1			
Rehabilitation Ward ODGH	2			
Short Stay Surgical 10B				
Short Stay Unit	2			
Spinal Injuries Unit				
Stroke Ward		1	1	
E Ward	1	1	1	
11A Surgical Ward	2	2	1	
Ward 11B		1		
Ward 14A	1			
Ward 14B	1	2		
Ward 15A - General Medicine		1		
Ward 7A		1		
Total	15	12	3	0

Table 3 shows the age profile of our nurse band 5 workforce across inpatient areas- we currently have 30 staff members over the age of 55 who, if those chose, could retire and subsequently further effect our vacancy rates.

5. **Recruitment and Retention**

Since November 2019 the following recruitment events have been held:

HCA Recruitment Day – 13th Dec
HCA Recruitment Day- 17th Dec
HCA Recruitment Day- 23rd Jan
RN Recruitment Day – 25TH Jan
HCA Recruitment Day- 3rd Feb
HCA Recruitment Day- 26th Feb
RN/HCA Recruitment Day – 14TH March

We have a planned approach to nursing and HCA recruitment and dates are already in the calendar for the next events which are as follows:

- HCA Recruitment Day – 13th June 2020
- Newly Qualified Recruitment Day – 24th & 25th June 2020.
- International Recruitment to commence June 2020

There are a number of ongoing initiatives to support the trust with recruitment and retention. These include:

- Building on bespoke adverts created for wards and departments and these are used alongside rolling recruitment campaigns.
- Focused work with the Ward Managers and Matrons on hard to recruit areas with regard to development opportunities available.
- Working with Communications and Human resources to promote the Trust as a great place to work through best use of social media; we have built a strong network of Trust nursing staff using Social Media to promote the Trust as an employer of choice.
- Implementation of Rotational posts within Adult Acute and Elective Care Divisions.
- The Trust acknowledges its requires to have a very strong focus on ensuring we appoint newly qualified nurses and we are actively engaging with these opportunities in communication with our local Health Education Institutes.
- A review of historical student placement numbers and a proposed significant increase in student nursing training placements at the trust.
- The Director of Nursing, the Deputy Director of Nursing and Assistant Director of Nursing Workforce meet now on a regular basis with nurses in training and on qualification.
- In recognition of the valuable contribution of the HCA workforce a review of the Care Certificate has commenced to support our current workforce and the potential HCA pipeline.
- The Care Support Worker Development (CSWD) programme run in collaboration with NHS Professionals (NHSP) has continued to support our pipeline of HCA's.
- Building on apprenticeship opportunities to nursing and Allied Health Professional roles.
- Seen a positive interest resulting in the first cohort of 18 final year Nursing students opting in to assume the role of "Aspirant Nurse" starting employment 27th April-20 in light of the unprecedented global Covid-19 pandemic.
- Supported and seen 10 Trainee Assistant Practitioners recently successfully complete their training to Band 4 Assistant Practitioner role.

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are currently 25 trained and trainee ANP/ ACPs within the Trust throughout the 3 CBUs and a further 8 allied health professional working at this higher level.

Allied Health Professionals

- There are 8 Advanced Physiotherapist working within the Trust that are MSc educated practicing at an autonomous level making complex decisions within their speciality of physiotherapy
- In May 2020 the Trust was given funding for a further 2 trainee ACPs from Health Education England, 1 post for urgent care within the AED department and 1 post for planned care for the development of a PICC line service. Planned care funding authorisation will require formalising aligned to business case submissions.
- It is hoped that Advanced Clinical Practitioner posts will increase in number once their value is realised to assist with the medical rotas and to assist in departments within the Trust to continue to deliver high standards of care to patients working with medical, nursing and allied health practitioners.

6. Temporary Staffing

When staffing numbers fall below agreed staffing levels within an area there are systems and processes in place that supports deployment across CBU's to mitigate immediate needs. Managers have the tools to fill gaps with temporary staffing through the trusts collaboration with NHSP.

Graphs 6&7 demonstrate our trust current fill rates against requests.

Graph 6- Bank and Agency shifts filled – Registered

Graph 7- Bank and Agency shifts filled – Unregistered

Staffing & Skill Mix Reviews Update by Clinical Business Unit (CBU)

7. Urgent Care Staffing Establishment Review

In line with the Trust nurse staffing reviews the Clinical Business Unit (CBU) last completed a comprehensive establishment review and presented to Board in May 2019. The CBU used evidence based modelling (Safer nursing care tool –SNCT), professional judgement and 'Confirm and Challenge' desk top supportive review process alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

Staffing Reviews Undertaken by DoN/DDoN Nov 19 – April 20

- All ward based areas (See table 4)
- Seasonal planning reviews due to additional contingency capacity
- Accident and Emergency requirements has identified increase to establishment through winter funding however a full establishment review with peer review is planned to be re-scheduled within the scope of works required post Covid-19 pandemic.

Table 4 – Establishment review outcomes

Ward	Recommended change within establishment
15a	Nil
15b	X1 HCA per shift
7a	Nil
7b	RN and HCA uplift x1 per shift - business case required to support uplift
11b	Band 5 vacancy to create development band 6 role
EAU	Uplift band 6 budget from band 5 budget to increase total band 6 to 5.6wte
9a SSU	Nil
9b FESS	Nil
14b	Nil – see below comment
MDU	Nil

11b and 15b – Changes to be effected in budgets (to be funded within the establishment) – DoN approval planned before change is processed.

14b – Final agreement regarding the Hyper Acute business case is sort to understand the implications on current budget.

Highlights Nov-April 2020

- Building on keeping in touch methods i.e. Brew and Review
- Latterly there has been a month on month reduction in hours requiring temporary staff fill, via agencies and in some cases use of premium cost agency's Nov 19 – April 20 on established wards. Further improvement must be balanced by requirements to maintain contingency ward staffing.
- HoN role redeployed and interim cover provided by Head of Older Peoples Care until August 2020 and will then be reviewed.

- Coronary Care Unit (CCU) was moved out of Critical Care at the start of the Covid-19 pandemic; into a bay on 7a which is a General Medical/Cardiology ward. This was done with support from the cardiac nurses, coronary care nurses and senior staff who delivered teaching around clinical competencies needed to care for CCU patients. In addition agency staff with cardiac experience were block booked to deliver cardiac care and this will feature in the next establishment review pending a decision regarding the long term plan for this service provision.

Re-modelling and Transformation Work streams update

In this period the CBU has seen the successful opening/closing of additional areas including the discharge lounge and the development of this within the ward 1 template as a more permanent fixture. There has been a requirement to create additional roles and also use staffing resources differently including the redeployment and upskilling of many staff who have been supported with skills/knowledge training and with support from Boo Coaching. Evidence from both quality and safety metrics and operational performance demonstrate that new models of working are effective and some of the temporary changes have led to discussions around opportunities to work differently in future. These are feeding into the phase 2 COVID-19 recovery programme board.

A programme of work to redesign frailty pathways focusing on admission avoidance and re-direction of patients for assessment from Accident and Emergency has bene underway with the practitioners working in AED and EAU to commence early comprehensive geriatric assessment, gain a full and holistic assessment and enable timely discussion about complex decision making in collaboration with the geriatric and medical colleagues. The team are enrolled on ACP training and funding was approved for the Trust to join the Acute Frailty Network, which has been postponed due to COVID-19.

Previous discussions and approval in May 2019 focused on development of new roles and staffing requirements as part of considering new models of care aligned to the Trust and clinical business unit strategic direction. As part of this, the stroke nurse provision was improved and has been hugely beneficial in providing timely stroke assessment in extended hours. In addition, the rehabilitation ward has been increasing the ability to manage more acute patients and particularly during COVID-19, the AED has been reconfigured to provide red (covid) and green (non-covid) streams to protect patients. Ward 11A has been utilised as a medical ward and not a surgical ward during this time as has ward 14A at times, and the staff in all of these areas have been supported in adapting to meet the demands.

Initiatives and Innovation

A review and business plan are being undertaken for the development of a respiratory level 2 care bay – staffing model will need to be developed.

CCU provision having been stepped out of the critical care unit onto ward 7A for COVID-19. A decision is to be made regarding the permanent location of this and the staffing model agreed accordingly.

AED and the emergency/same day care pathways are under review with a view to developing more streamlined and appropriate pathways for patients and managing surges through planning activity with primary care and community colleagues – workforce will be incorporated within this review.

Recruitment and Retention:

- Listening events (Brew and Review) for, HCA and new nursing staff and revised preceptorship programme with planned review points and a celebration awards ceremony to recognise achievements.
- Revised Preceptorship programme launched.
- Presence at all Trust recruitment events.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level (see table 3):

Table 5-Urgent Care Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	4
Assistant Practitioner	14
Nursing Associate	12
Senior Healthcare Support Worker L3	6
Total	**36**

Over the next 12 month period the Trust, will aim to utilise apprenticeship levy funding to develop the current workforce using the existing pathways:

Additional Roles

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are 2 consultant nurses working on ACU, both are due to retire soon.
- There are currently 4 trained ACPs working within AED who have completed their Masters and RCEM speciality training.
- There is a trainee ACP working on ACU who was due to complete their Masters in May 2020, unfortunately this finish dates have been deferred to later in the year due to the COVID-19 pandemic.

Workforce Analysis

Registered Nurse Vacancy Position

The Urgent Care CBU has 104wte band 5 vacancies at the end of April 2020. This reflects the previous nurse staffing establishment uplift in May 2019 and requirements to staff seasonal contingency/COVID-19 areas.

Table 6 – Urgent Care Band 5 inpatient ward areas vacancy

Table 7 below shows the age profile of our nurse band 5 workforce across inpatient areas in the Urgent Care CBU, currently reporting to have 13 staff members over the age of 55 (Trust inpatient total =30).

Table 7-Urgent Care Inpatient Band 5 age profile > 55yrs

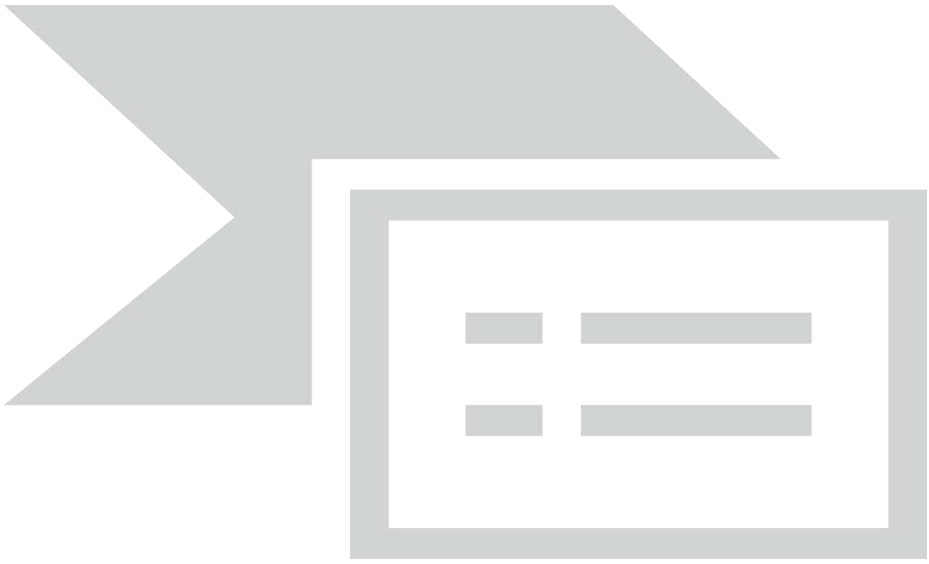
Ward	56-60	61-65	66-70	>=71 Years
Emergency Assessment Unit	1			
FESS Ward				
Rehabilitation Ward ODGH	2			
Short Stay Unit	2			
Stroke Ward		1	1	
Ward 11B		1		
Ward 14B	1	2		
Ward 15A - General Medicine		1		
Ward 7A		1		
Total	6	6	1	0

Graph 8 - CBU vacancy nurse **band 5 inpatient areas** position charts

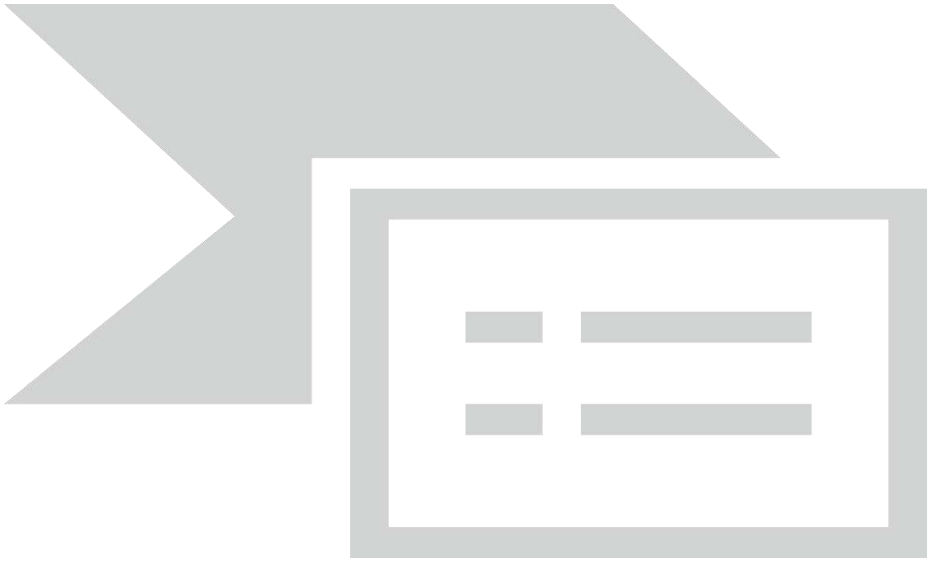
Temporary staff

There has been a reduction in agency use however this has been masked due to staffing requirement for contingency ward areas and use of agency staff. Of particular note there has been a significant reduction in the reliance on premium agencies and off framework agencies and a clear process is now in place for escalation to DoN, DDoN, should off framework support be needed only in the most exceptional circumstances. Agency block booking has supported areas with high level vacancy, until RN recruitment figures improve.

Graph 9 -CBU inpatient Registered shifts filled bank/agency



Graph 10- CBU Non Registered shifts filled by bank



8. Planned Care Clinical Business Unit -Staffing Establishment Review

In line with the Trust nurse staffing reviews the Clinical Business Unit (CBU) completed a comprehensive establishment review and presented to Board in May 20219. The CBU used evidence based modelling (Safer nursing care tool –SNCT), professional judgement and 'Confirm and Challenge' desk top supportive review process alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

Staffing Reviews Undertaken Nov 19 – April 20

- All ward based areas (See table 11)
- Seasonal planning reviews due to additional contingency capacity

Table 8 – Establishment review outcomes

Ward	Required change within establishment
14a	Increase band 6 from 0.74 to 1 wte Increase band 2 by 2.75 wte due to bank/agency spend.
11a	Nil
10b	Nil
ITU/CCU	Increase x1 wte HCA per shift
E, F & G	Band 5 vacancy to create development band 6 role
SIU	Review remains outstanding – booked for June 2020

Highlights Nov- April 2020

- Remodelling and transformation of the ACP workforce
- Remodelling ODGH site
- COVID-19 – impact on Theatres/CCU

Re- Modelling and Transformation work streams update

Theatres

A complete staffing review for theatres is required with peer review and is planned within the future staffing establishment reviews. The current risks relating to theatre are detailed on the CBU risk register and reviewed on a monthly basis. In addition we are working to develop new roles and models of working to assist in recruitment and retention of theatre staff

Recruitment and retention

- Listening events (Brew and Review) for, HCA and new nursing staff and revised preceptorship programme with planned review points and a celebration awards ceremony to recognise achievements.
- Revised Preceptorship programme launched.
- Presence at all Trust recruitment events.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level (see table 8):

Table 9 -Planned Care Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	3
Assistant Practitioner	4
Nursing Associate	12
Senior Healthcare Support Worker L3	7
Total	**26**

Additional roles

Nursing Associates and Trainee Nursing Associates
The CBU continue to provide training for our Trainee Nursing Associates and earlier this year welcomed the first qualified Nursing Associate into the Out Patient Department.

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are currently 9 trainee ACPs all on different stages of the MSc.
- On the Southport site a SAU service was set up approx. 18months ago with a plan to staff this unit with ACPs. The unit has been successful in completing its KPIs to date and there is ongoing development planned within this unit. This service is currently staffed with 2 trainee ACPs who are both due to complete their Masters this year. There is also a bank ACP and Physicians Associate working within SAU.
- On the Ormskirk site is staffed with RMO covering 24hours, 7 days a week. This is complemented with an ACP team of 6. At present there are 3 trainee ACPs, 1 due to complete MSc in 2021, 1 in 2022 and 1 in 2023. Also there are currently 3 vacant posts which are currently being advertised. 1 vacancy was filled with a trainee ACP in June 2020 and is due to start in August 2020.
- In 2019 ITU was granted funding from HEE for 2 trainee Advanced Critical Care Practitioners, these practitioners began their MSc in 2019, due to complete their MSc in September 2021. It is proposed that these 2 posts will complement the ITU/ HDU rotas as it is hard to recruit medical practitioners with this area.
- In January 2020, an Advanced Orthopaedic and Frailty Practitioner were interviewed and are due to commence in post in June 2020

Workforce analysis

Registered Nurse Vacancy Position
The Planned Care CBU has 43wte band 5 vacancies at the end of April 2020. This reflects the previous nurse staffing establishment uplift in May 2019 and requirements to staff seasonal contingency/COVID-19 areas.

Table 10 – Planned Care Band 5 Vacancy

Planned Care

Nurse Band 5	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Funded WTE	213	228	228	227	227	227	227	228	228	232	233	232	233
Contracted WTE	181	183	184	180	179	176	180	187	186	192	190	190	190
Vacancy WTE	32	45	44	46	48	51	46	40	42	39	43	42	43

Predicted Vacancy
As with other CBUs, the ability to maintain the pace of recruitment to turnover presents a challenge which results in a continuous vacancy. The vacancy levels documented above include the acute ward areas, and critical care.
Working in collaboration with colleagues in finance and HR, the clinical business unit have committed to reviewing how by recruiting substantively to vacancy, turnover and mat leave, the need for bank and agency can be reduced. We will not get into a position whereby bank and agency can be eliminated until the clinical business unit reaches its agreed and planned recruitment figure. International recruitment will feature in this plan alongside retention and increase to our student numbers.

Table 11 below shows the age profile of our nurse band 5 workforce across inpatient areas in Planned Care CBU, currently reporting to have 17 staff members over the age of 55 (Trust inpatient total =30).

Table 11- In patient Band 5 age profile > 55yrs

Ward	56-60	61-65	66-70	>=71 Years
F WARD SURGICAL DAYCASE				
ODGH	3			
G Ward (EL Orthopaedics)		1		
ITU CCU	1	2		
Orthopaedic Rehab ward (H)	1			
Short Stay Surgical 10B				
Spinal Injuries Unit				
E Ward	1	1	1	
11A Surgical Ward	2	2	1	
Ward 14A	1			
Total	9	6	2	0

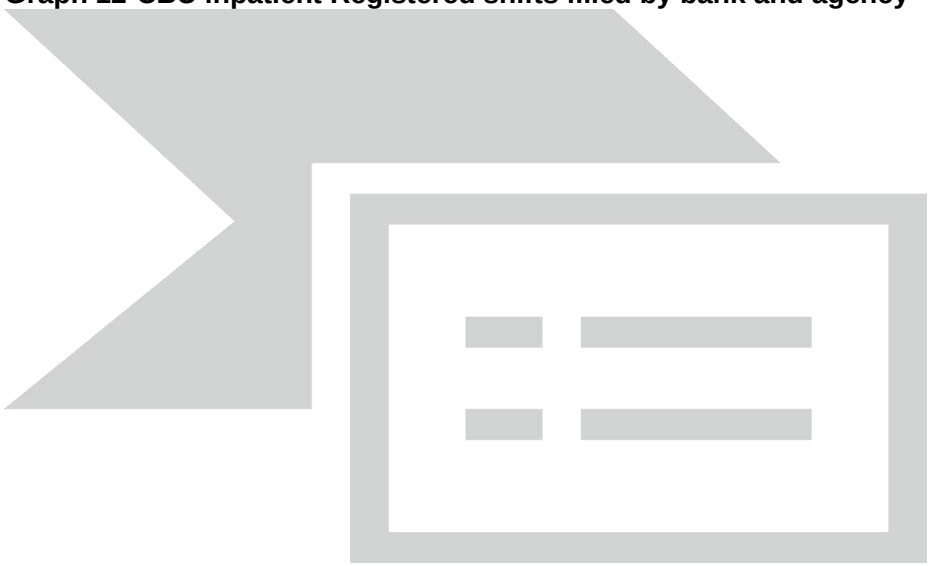
Graph 11- CBU vacancy nurse **band 5 inpatient areas** position charts

The establishment for band 5s increased in May 2020 as all of H Ward was funded (an additional 6.58wte band 5 RN's).

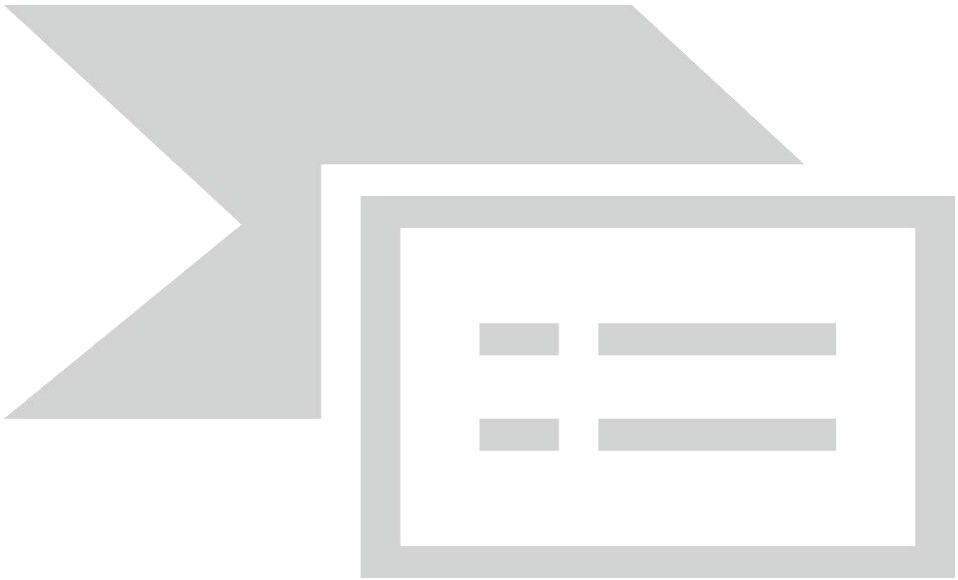
Contingency Area requirements

As part of contingency planning for winter, the clinical business unit altered the use of the elective orthopaedic ward and the staffing establishment. This resulted temporary staffing use. In addition the clinical business unit moved staff to Acute Adult ward areas to support the bed base and patient flow on the Southport Hospital site and moved staff to support the opening of ward 1 on a number of occasions and during the pandemic. Preparation for next winter is underway along with a review of the staffing plan for planned care utilisation of beds on the Ormskirk site not forgetting additional capacity to minimise the impact of temporary staffing.

Graph 12-CBU inpatient Registered shifts filled by bank and agency



Graph 13- CBU Non Registered shifts filled by bank



9. Specialist Services – (Children's Services and Maternity Services)

In line with the Trust nurse staffing reviews the CBU last completed a comprehensive establishment review and presented to Board in May 2019. To undertake the reviews, the CBU uses the Royal College of Nursing evidence based modelling, professional judgement and 'Confirm and Challenge' desk top exercise, alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), and acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and, for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

10. Children's services

This service encompasses general and specialist care provision across neonates to young people of 16 years with Cystic Fibrosis patients transitioning at 17 years, Diabetes patients transitioning at 18 years and young people with complex needs transition at 16 -17 year.

Workforce analysis

The paediatric unit does not currently always have supernumerary shift leader due to the flow of activity and acuity, however there is a coordinator identified and staffing is flexed to support and ward managers are supernumerary 5 days per week. Further review is planned to check the ratios against activity / acuity in preparation for the next staffing review.

Neonatal staffing is aligned to BAPM standards and within this establishment review a statement of case has been developed to support a number of changes including transitional care and options for implementation of a supernumerary shift coordinator to comply with BAPM standards.

Registered Nurse Vacancy Position

Table 12

Specialist Services

Nurse Band 5	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Funded WTE	53	62	62	62	62	62	62	62	62	56	56	56	56
Contracted WTE	63	65	64	61	62	63	66	67	66	66	66	64	61
Vacancy WTE	(10)	(3)	(1)	1	(0)	(1)	(4)	(5)	(4)	(10)	(10)	(8)	(5)

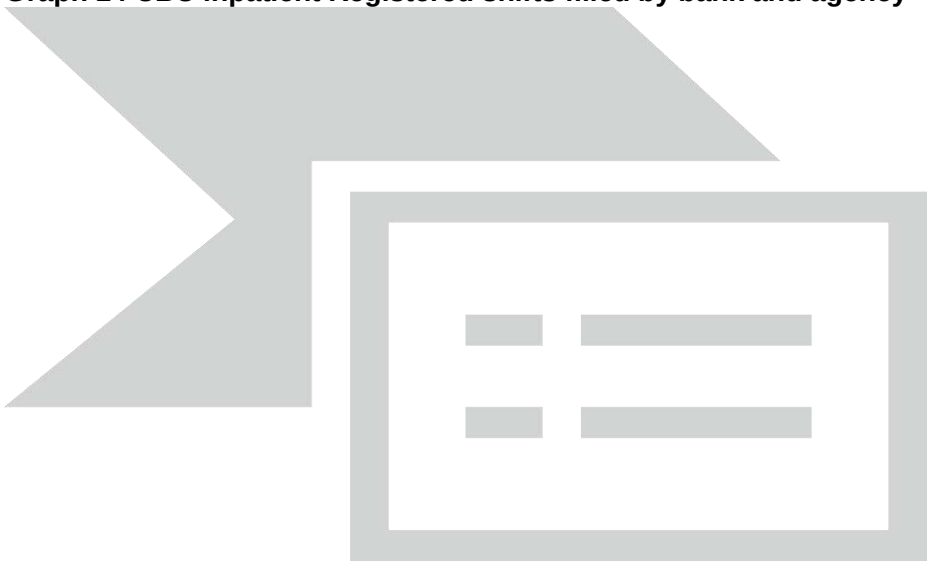
Historically there has been successful recruitment to vacancies, however in 2019 there were some problems due to tertiary hospitals offering all the students posts. The trust has now recently appointed 7.96 WTE for across the Paediatric Unit due to commence in post Mid-September 2020 after qualifying. This will put the unit up to full establishment.

The unit has very high levels of maternity leave over the last year and continuing this year and this has been supported via temporary staffing and NHSP.

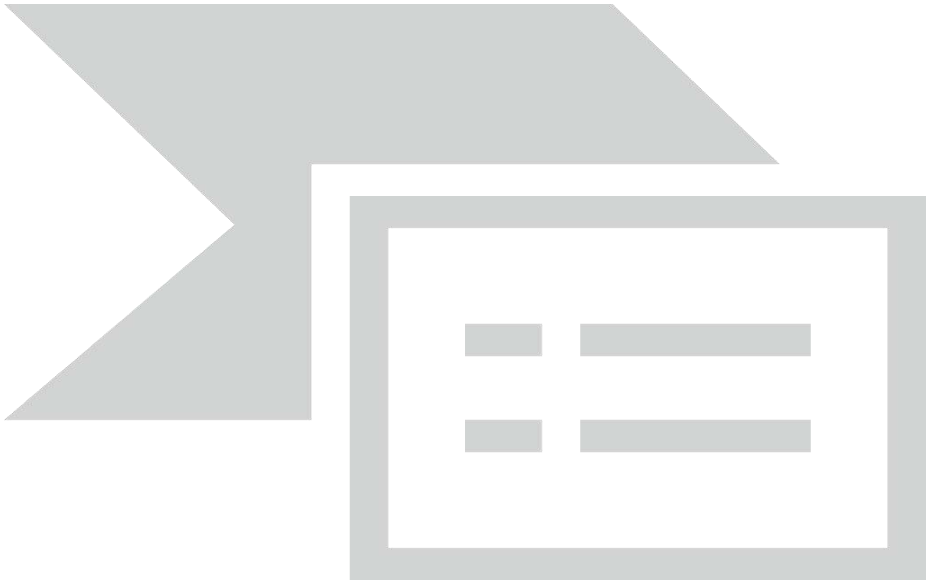
In response to COVID-19 and demands on medical staff, Paediatric A&E closed at night from the 6th April 2020, and this has allowed staffing to be managed safely with little reliance on NHSP along with reduction of activity during the pandemic. The patient flow is now starting to increase.

Matron meets with the Ward leaders on a weekly basis to discuss staffing for the week. Ward leaders are expected to review staffing on a daily basis. The weekend is always checked on a Friday and plans in place if staff are off sick and unsure whether resuming.

Graph 14 CBU inpatient Registered shifts filled by bank and agency



Graph 15 - CBU Non Registered shifts filled by bank



Staffing is reviewed in the twice daily safe staffing huddles and Matron meets with Band 7's on a weekly basis to discuss staffing for the week and the ward managers review on a daily basis. The weekend is always checked on a Thursday.

Table 13 -Children's Services Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	2
Total	**2**

In response to the staffing review in December 2019, it was agreed to increase the number of Band 6 staff and slightly reduce Band 5 in order to ensure senior cover across all areas 24/7.

Advanced Nurse Practitioners (ANP) Advanced Clinical Practitioners (ACP)

- 5 trained ACPs working within Paediatric AED (1), ward based (3), neonates (1).
- There is 1 trainee ACP working within Paediatric AED who has completed her MSc and is due to complete their specialty competencies in August 2020 and 1 bank ACP also working within AED. All of these staff works alongside the Paediatric medical staff.

11. Maternity Staffing Review For the Period July 2019 to April 2020 (inclusive)

In accordance with requirements for NICE standards for Maternity staffing 'Safe Midwife Staffing in Maternity Settings' (2015), and Clinical Negligence Scheme for Trusts, a bi annual report should be submitted to the Board to provide assurance that the midwifery establishments are safe and that staff are able to provide appropriate levels of care to women and babies. The last staffing review was presented in August 2019 for period January to June 2019. Therefore in order to incorporate the data within the timeframe since the last presentation to Trust Board, this review will cover the above period.

Birth Rate Plus Acuity assessment to calculate the required establishment

A Birthrate Plus assessment (BR+) was last commissioned in February 2019. BR+ is a framework for workforce planning based upon an understanding of the total midwifery time required to care for women and includes a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings (2015), and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetrics & Gynaecology (RCOG).
The calculations for staffing are attached in Appendix 1.

The outcome of the assessment identified the following:

Table 14- Midwifery establishment

Midwives	Current Establishment	BR+ Recommendations	Variance
Clinical Midwives	92.32wte	93.77wte	**- 1.45wte**
Non Clinical role/ Specialist Midwives	6.00wte	8.44wte	**- 2.44wte**
Total	98.32wte	102.21wte	**- 3.89wte**

Table 15- Support Worker establishment

Maternity Support	Current	BR+	Variance

Workers	Establishment	Recommendations	
Band 3/4	6.84wte	9.38wte	**- 2.54wte**
Band 2	10.40wte	12.00wte	**- 1.6wte**
Total	17.24wte	21.38wte	**- 4.14wte**

For this reporting period a 'table-top' exercise has taken place based on the criteria for birthrate plus for this reporting period with no change to previous report. Therefore the ratio of births to midwives is:

Table 16

Birth Rate Plus Ratio	Recommended ratio of births to midwives is 1 Midwife to 26 births

The overall ratio for number of births to number of midwives for Maternity Services are not directly comparable to other Maternity providers because of the local factors involved.

In view of 'Better Births' recommendations "Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally." This is a shift from our more traditional model of midwifery care to a more flexible team approach with the focus on the women and their families. In response to this Maternity has developed a new workforce model which will require an organizational change and need financial support to implement. An options appraisal was presented at Performance Review Board and Hospital Management. Following this the Director of Nursing has commissioned an external assessment by Maternity specialists in NHSI to evaluate options and benchmark against other provider before making recommendations to the Board.

Action Plan to Address Findings from BR+

An action plan has been implemented to address the findings from the BR+ audit because deficits in staffing levels have been identified. This is attached in Appendix 2.

Planned versus actual midwifery staffing levels including evidence of mitigation /escalation for managing shortfalls

- Roles and responsibilities for maternity staffing are outlined in the Maternity Services Standard Operating Procedure (Number 52) for Staffing Levels and Maternity Services Standard Operating Procedure (Number 53) for Maternity Escalation
- Maternity has roster check and challenge meetings to ensure effective and efficient use of the roster against E Rostering KPI's and completing of the daily safe staffing process.
- Fill rates are published monthly with Maternity consistently monthly over 90%
- Staffing is discussed as part of the Delivery Suite Shift Coordinator hand over as they have the overview of daily staffing levels. This takes place twice a day, and ward dependency, acuity and overall staffing ratios/ gaps are discussed.
- Staffing levels and staffing issues are reported via DATIX and reviewed as part of the Patient Safety Meetings

Supernumerary Status of the Delivery Suite Shift Coordinator

The delivery suite shift coordinator is supernumerary to enable them to fulfil their role, which is pivotal in providing effective leadership, clinical expertise, facilitating communication between professionals and overseeing appropriate use of resources. The shift coordinator was rostered as supernumerary 100% of the time. Compliance with supernumerary status was 99%. This was because there were some occasions where there has been a need for the coordinator to care for women for short term (less than 3 hours).

Percentage for Provision of One to one Care in Labour

Maternity services aim to achieve 100% 1-1 care in labour and this is monitored via the Maternity Information System and where this cannot be provided a DATIX incident report is completed which is recorded as a 'red flag'. During the reporting period there has been one occasion when one to one care could not be provided. This was because the midwife was required to scrub for an emergency caesarean section. This was an anticipated risk following review of the theatre provision and has been risk assessed.

Staffing related incidents and Red flag indicators

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. Maternity Services Standard Operating Procedure for Maternity Services Staffing reflects the recommended reporting guidance. This data is collected via the DATIX incident reporting system and monitored via the Maternity Dashboard. All red flag incidents are also discussed at the weekly Patient safety Meeting and cross referenced with clinical incidents. For this reporting period there were 20 logged incidents in relation to maternity staffing.

Midwifery Red Flag Indicators

Table 17

July 2019 – April 2020	
Midwifery Red flag	**Incidents**
Delayed or cancelled time critical activity	5
Missed or delayed care (delay of 60 minutes or more in washing and suturing).	
Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).	1
Delay of more than 30 minutes in providing pain relief or medication	
Delay of 30 minutes or more between presentation and triage.	
Full clinical examination not carried out when presenting in labour.	
Delay of 2 hours or more between admission for induction and beginning of process.	13
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	1 (explained above)

The red flag data demonstrated an issue with '*Delayed or cancelled time critical activity' (5)* and '*Delay of 2 hours or more between admission for induction and beginning of process' (13)* These related mainly to two periods of time in September and November when there was delay in commencing the induction process due to increased acuity and activity in the maternity unit. There were no patient safety issues identified.

Highlights

- Senior Midwifery oversight until 8pm and at weekends has been introduced to support staff by having a 'helicopter view'. This enables efficient response to any staffing shortfalls, unpredicted demands on the service and any other concerns that may arise.
- Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting
- An acuity tool has been implemented on Delivery Suite and the Maternity Ward to monitor activity and patient acuity against midwifery staffing. This is still being embedded.
- During the reporting period the maternity unit did not close

- During the reporting period the home birth service was temporarily suspended from 30th March 2020 to 18th May 2020, due to staffing levels and effects of COVID
- In response to COVID staff in the 'at risk' groups have been supported either by working in non-patient facing environments, working from home or being shielded. Whilst Sickness absence rates increased to 14-15% this has been managed well with the support of staff working flexibly or on NHSP. Sickness absence rates are now demonstrating improvements.
- Maternity Services does not experience any difficulties recruiting staff with high numbers of applicants for posts. Turnover rates are currently less than 1% for this reporting period

Next Steps

- Confirm next steps regarding Continuity of Carer with Director of Nursing & Midwifery COC Workforce
- Liaise with Cheshire & Merseyside Local Maternity System regarding central funding for Birthrate Plus assessment in 2020
- Embed the intrapartum/ward acuity tool

12. Conclusion

. As with previous reports, the Trust continues to carry a number of nursing vacancies. This is reflected in the Trust Board Assurance Framework (BAF) and the Clinical Business Unit's Risk Registers.

Reviews of staffing numbers and skill mix will continue to be ongoing with the next Bi-annual staffing review commencing July 2020. The trust will incorporate outcomes of national patient acuity tools with future establishment reviews and proposed changes will be based on triangulation of acuity, current quality indicators and outcomes and professional judgement, whilst taking into account any available national guidance.

13. Recommendation

The Board is asked to receive the report, support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.

Finally, the Board is also asked to recognise and commend the work and efforts of the entire nursing and midwifery workforce who are committed to, and continue to deliver safe and effective care whilst working in the recent challenging environment.

Report authors:

- Claire Harrington – Deputy Director of Nursing
- Carol Fowler – Assistant Director of Nursing – Workforce

In collaboration with:

- HoN- Stephen Mellars
- HoN- Grace Delaney Segar & Megan Langley
- HoM- Lynne Eastham

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB115/20**	**FOI Exempt**	**No**
Report Title	**Bi Annual Staffing Establishment review**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Claire Harrington, Deputy Director of Nursing Carol Fowler, Assistant Director of Nursing Workforce		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides a comprehensive update on nurse and midwifery staffing, mainly focusing within the inpatient bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

Executive Summary

Overview

The Trust is required to complete and report bi-annual nurse staffing review activity. The purpose of this paper is to provide context of these reviews, actions taken, and also to provide broader context of Nursing and Midwifery staffing models, innovation and direction for the next 6 months. This report is the first following the initial review presented to Trust Board May 2019 concluding in an agreed uplift in nurse staffing of Registered nurse of 54.53 wte, HCA 59.28 wte and Ward Clerks 3.27 wte. This is reflected in rosters and is reflected in the Trust vacancy rate reported in this paper.

Key Points in this paper

- Urgent Care 104 band 5 (inpatient ward area) vacancies
- Planned Care 43 band 5 (inpatient ward area) vacancies
- Specialist services (inpatient ward areas) – 5 wte over funded establishment
- Strong performance in the recruitment to HCA vacancies
- Positive engagement and growth of advanced roles across the CBU's with further planned
- Positive engagement with apprenticeship opportunities with growth planned
- Realignment within current budgeted establishment to support development roles.
- Registered Nurse fill by agency is reducing

Actions and Next steps

- The report demonstrates that current recruitment plans are not significantly impacting on vacancy rate in medicine and surgery
- Therefore as part of the wider recruitment and retention plan, a step change is expected in the next 6 months to reduce the immediate, medium and long-term vacancy rate. This includes strategic partnership working with Universities, international recruitment 2020, growth by 50% of students in 2020/21 targeting local population, nurse apprenticeship roles using Levy.
- The Director of Nursing will become part of the regional work stream working with Health Education England to ensure Southport and Ormskirk is centric to developing workforce options regionally
- Allied Health Professional workforce will be included in future reporting as it is expected following the next staffing reviews that the clinical workforce will need to be reviewed as a whole to provide context and also to explore innovation and alternative roles

Recommendation

The Board is asked to receive the report and support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	☐ **Quality & Safety Committee** ✓ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
✓ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Claire Harrington, Deputy Director of Nursing Carol Fowler, Assistant Director of Nursing, Workforce	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance

Comprehensive Bi-Annual Nurse Staffing Paper

1. Purpose

This report provides the Board with a comprehensive update on nurse and midwifery staffing, mainly focusing within the bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

2. Background and Context

It is well recognised nationally, that the shortfall in registered nurses is one of the most urgent needs to address for all NHS providers. Improving the workforce shortages in nursing is one of the five specific workforce challenges outlined in the Interim NHS People Plan published in June 2019.

As a result of the covid-19 pandemic, we have had to manage a constantly changing workforce situation to ensure patient and staff safety. This is particularly apparent in April 2020 data which is skewed due to high levels of absence, decrease in numbers of inpatients and use of additional staff from other areas and professions e.g. therapies to fill roster gaps and ensure safe staffing.

3. Current Position

The charts (Table 1, Graph 1) provide a breakdown of our UNIFY fill rate data (November 2019 to April 2020 inclusive) collected and submitted externally on a monthly basis for our inpatient areas. It shows a percentage of the Planned v Actual staffing levels for both the Day and Night shifts split by registered and unregistered. The

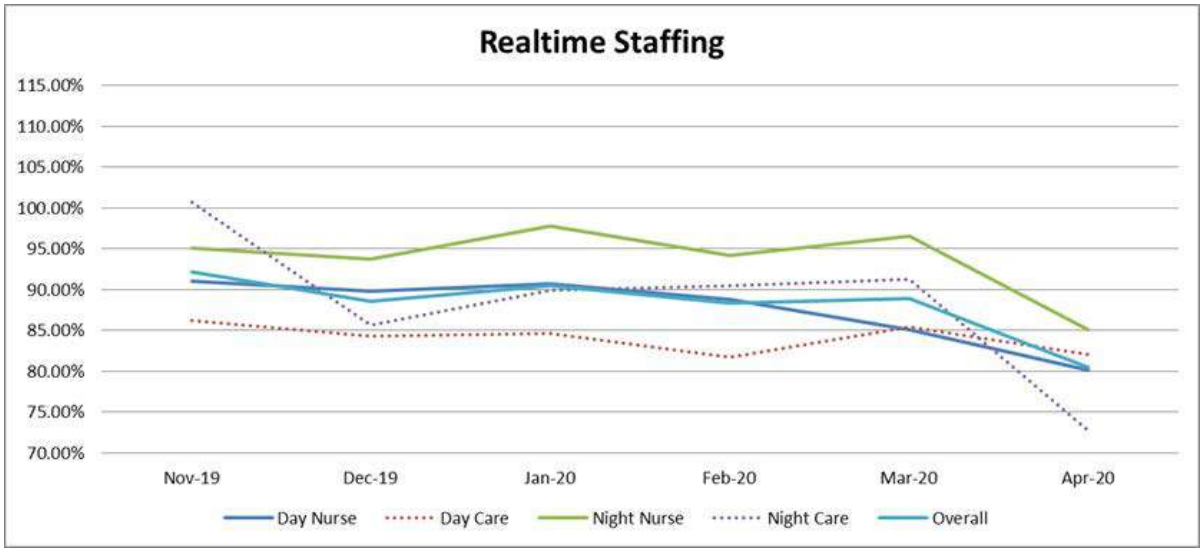
During 2019-2020, through critical appraisal the Trust commenced a review of the data sources to support a single source of the truth to the workforce data reporting including UNIFY return.

In addition, we have worked on reviewing all the inpatient demand templates to ensure accuracy of reporting to consider all new and emerging roles (such as Assistant Practitioners (AP's), Nursing Associates (NA's), Advanced Nurse Practitioners (ANP/ACP's) etc.

Table 1- Percentage fill rate – Unify Submission Nov19-April 20

Month	Registered Day %	Unregistered Day %	Registered Night %	Unregistered Night %
Nov-19	91.09%	86.23%	95.13%	100.65%
Dec-19	89.82%	84.26%	93.77%	85.60%
Jan-20	90.73%	84.59%	97.73%	89.91%
Feb-20	88.76%	81.73%	94.16%	90.42%
Mar-20	85.07%	85.42%	96.59%	91.29%
Apr-20	80.13%	82.00%	85.05%	72.72%
Average	87.60%	84.04%	93.74%	88.43%

Graph 1- Nov 19 – April 20 Fill rates



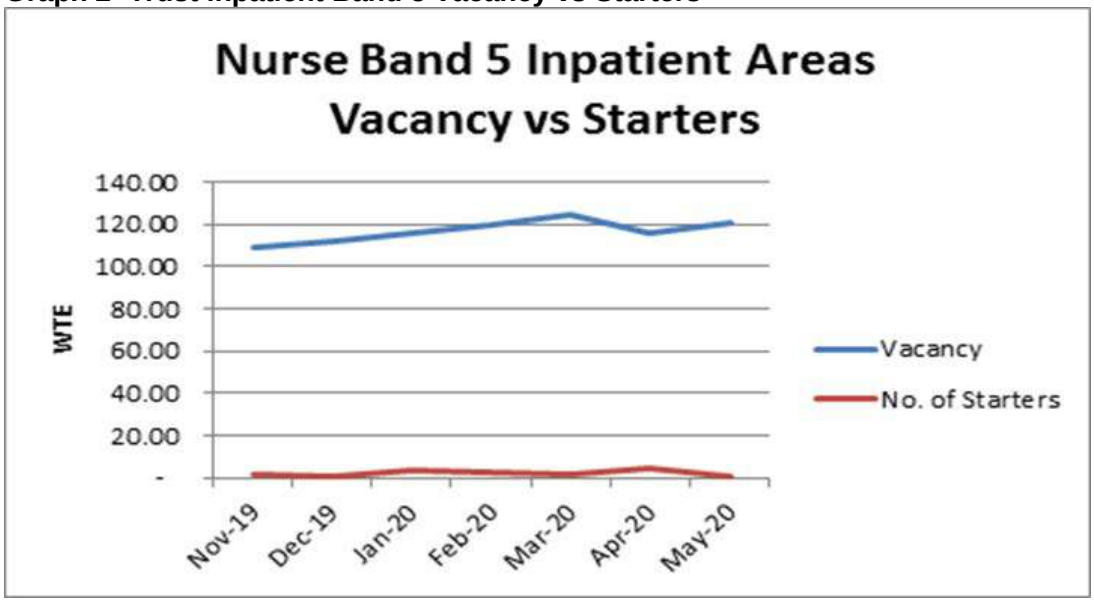
4. Vacancies

Graph 2 below demonstrates that the Trust has seen 24wte Registered Nurse starters across this reporting period. The starters data is taken from ESR and vacancy from the finance ledger.

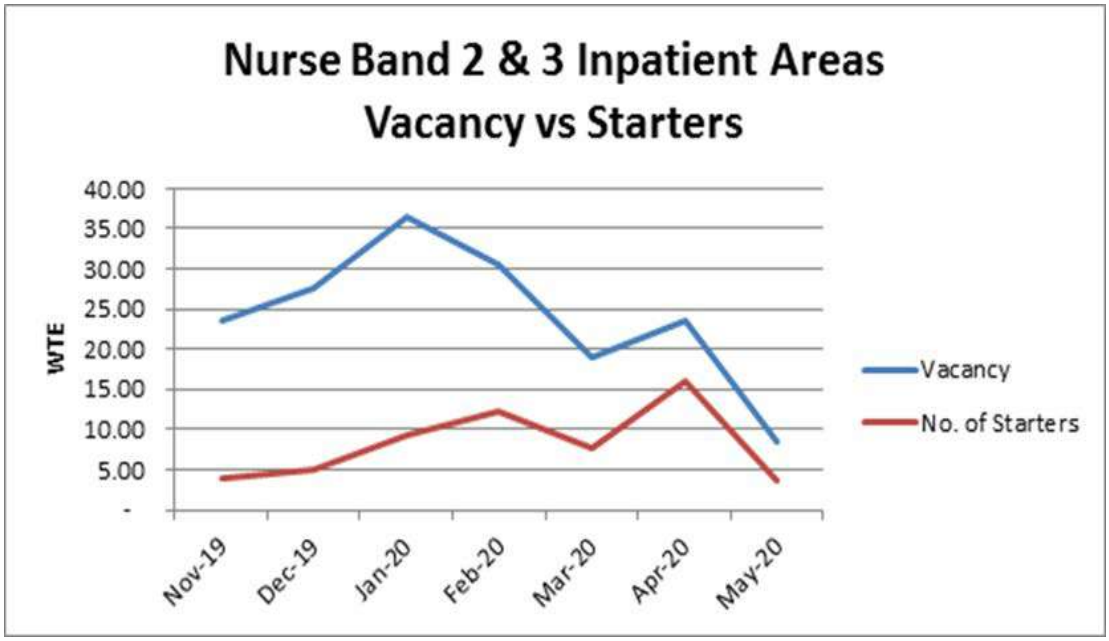
Graph 3 shows stronger performance against recruitment of HCA staff with 78.44wte starters across this reporting period. The starters data is taken from ESR and vacancy from the finance ledger.

Graph 4 reflects the response to the pandemic and the recruitment to the students into band 4 roles prior to their registration to the Nursing and Midwifery Council (NMC). The starters data is taken from ESR and vacancy from the finance ledger.

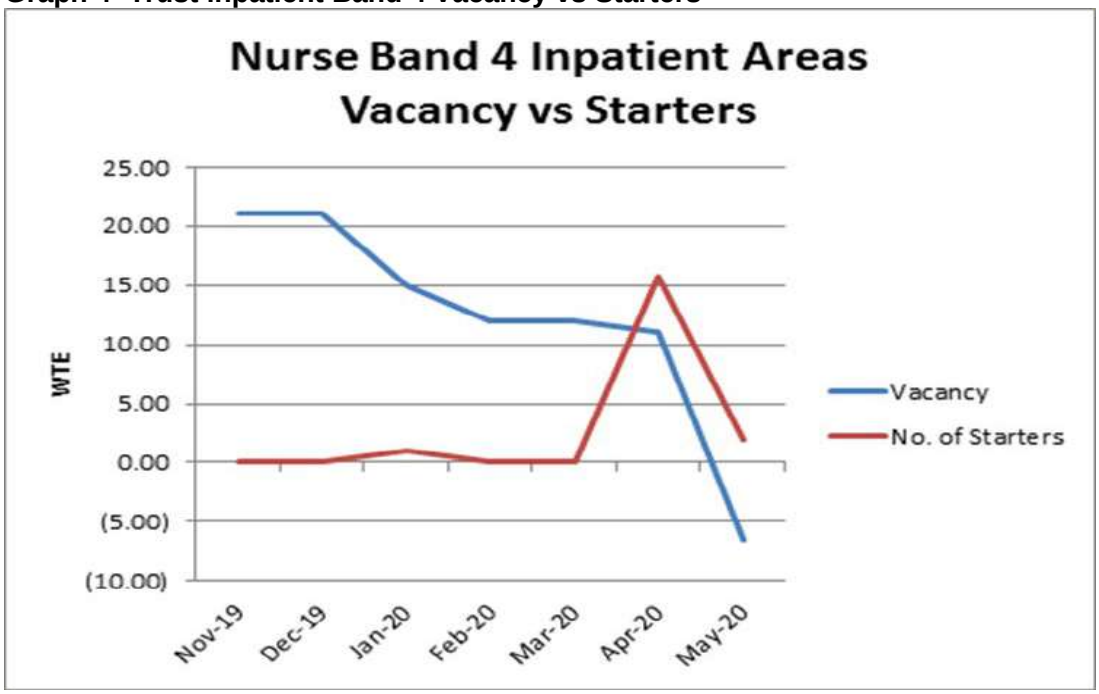
Graph 2 -Trust inpatient Band 5 Vacancy vs Starters



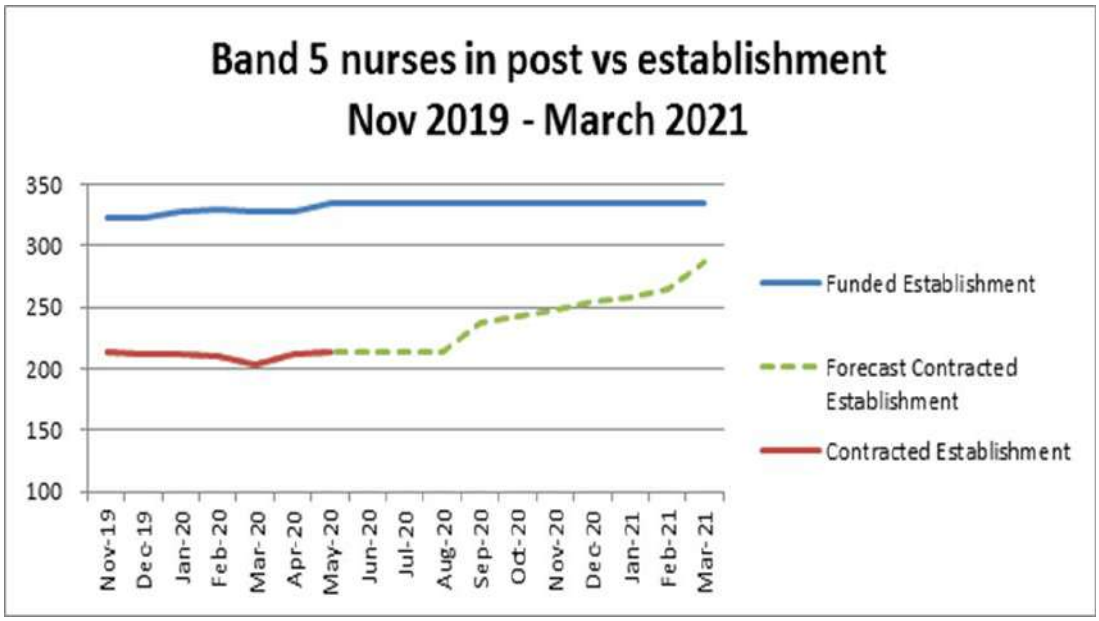
Graph 3 -Trust inpatient HCA Vacancy vs Starters



Graph 4 -Trust inpatient Band 4 Vacancy vs Starters



Graph 5 –Trust Band 5 nurses versus establishments



Graph 5 illustrates both the funded and contracted establishments for nurse band 5 nurses within inpatient areas between the period November 2019 to March 2021. From June 2020 onwards the contracted establishment has been predicted based on a number of assumptions including: turnover rate, student recruitment, retirees and international recruitment commencing in September 2020.

The predicted retirees figures included in the forecast above are based on actual retiree numbers between April 2019 – March 2020.

Table 2 –Predicted recruitment impact -Nurse Band 5 vacancies

Vacancy levels Band 5 Nurses	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual Vacancy (WTE)	109	112	116	119	124	115	121										
Turnover (WTE)								4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7
Recruitment (WTE)								(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
Students (WTE)											(18)						(18)
Retirees (WTE)											0.4	0.4	0.4	0.4	0.4	0.4	0.4
International Recruitment (WTE)											(5)	(6)	(5)	(6)	(5)	(6)	(5)
Net Vacancy (WTE)	**109**	**112**	**116**	**119**	**124**	**115**	**121**	**120**	**120**	**120**	**97**	**91**	**86**	**80**	**75**	**69**	**47**

Table 2 illustrates the predicted impact on nurse band 5 vacancies for inpatient areas over the following months. The turnover, recruitment and retirees figures are based on actual Trust figures from April 2019 – March 2020. International recruitment is set to commence in June with starters anticipated from September 2020 onwards. Due to the impact of COVID-19 the figures present an assumed position that there will be no retirees until September 2020.

Table 3-Trust age profile > 55yrs -Band 5 – inpatient areas

Ward	56-60	61-65	66-70	>=71 Years
F WARD SURGICAL DAYCASE ODGH	3			
G Ward (EL Orthopaedics)		1		
Emergency Assessment Unit	1			
FESS Ward				
ITU CCU	1	2		
Orthopaedic Rehab ward (H)	1			
Rehabilitation Ward ODGH	2			
Short Stay Surgical 10B				
Short Stay Unit	2			
Spinal Injuries Unit				
Stroke Ward		1	1	
E Ward	1	1	1	
11A Surgical Ward	2	2	1	
Ward 11B		1		
Ward 14A	1			
Ward 14B	1	2		
Ward 15A - General Medicine		1		
Ward 7A		1		
Total	15	12	3	0

Table 3 shows the age profile of our nurse band 5 workforce across inpatient areas- we currently have 30 staff members over the age of 55 who, if those chose, could retire and subsequently further effect our vacancy rates.

5. **Recruitment and Retention**

Since November 2019 the following recruitment events have been held:

HCA Recruitment Day – 13th Dec
HCA Recruitment Day- 17th Dec
HCA Recruitment Day- 23rd Jan
RN Recruitment Day – 25TH Jan
HCA Recruitment Day- 3rd Feb
HCA Recruitment Day- 26th Feb
RN/HCA Recruitment Day – 14TH March

We have a planned approach to nursing and HCA recruitment and dates are already in the calendar for the next events which are as follows:

- HCA Recruitment Day – 13th June 2020
- Newly Qualified Recruitment Day – 24th & 25th June 2020.
- International Recruitment to commence June 2020

There are a number of ongoing initiatives to support the trust with recruitment and retention. These include:

- Building on bespoke adverts created for wards and departments and these are used alongside rolling recruitment campaigns.
- Focused work with the Ward Managers and Matrons on hard to recruit areas with regard to development opportunities available.
- Working with Communications and Human resources to promote the Trust as a great place to work through best use of social media; we have built a strong network of Trust nursing staff using Social Media to promote the Trust as an employer of choice.
- Implementation of Rotational posts within Adult Acute and Elective Care Divisions.
- The Trust acknowledges its requires to have a very strong focus on ensuring we appoint newly qualified nurses and we are actively engaging with these opportunities in communication with our local Health Education Institutes.
- A review of historical student placement numbers and a proposed significant increase in student nursing training placements at the trust.
- The Director of Nursing, the Deputy Director of Nursing and Assistant Director of Nursing Workforce meet now on a regular basis with nurses in training and on qualification.
- In recognition of the valuable contribution of the HCA workforce a review of the Care Certificate has commenced to support our current workforce and the potential HCA pipeline.
- The Care Support Worker Development (CSWD) programme run in collaboration with NHS Professionals (NHSP) has continued to support our pipeline of HCA‘s.
- Building on apprenticeship opportunities to nursing and Allied Health Professional roles.
- Seen a positive interest resulting in the first cohort of 18 final year Nursing students opting in to assume the role of “Aspirant Nurse” starting employment 27th April-20 in light of the unprecedented global Covid-19 pandemic.
- Supported and seen 10 Trainee Assistant Practitioners recently successfully complete their training to Band 4 Assistant Practitioner role.

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are currently 25 trained and trainee ANP/ ACPs within the Trust throughout the 3 CBUs and a further 8 allied health professional working at this higher level.

Allied Health Professionals

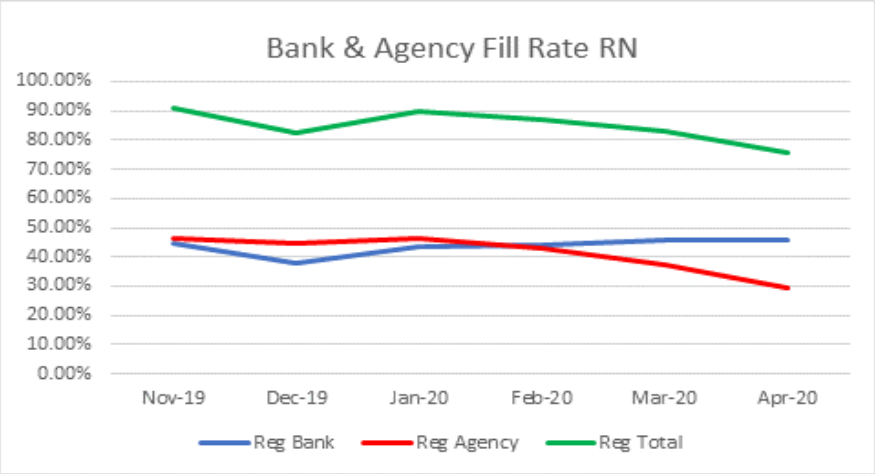
- There are 8 Advanced Physiotherapist working within the Trust that are MSc educated practicing at an autonomous level making complex decisions within their speciality of physiotherapy
- In May 2020 the Trust was given funding for a further 2 trainee ACPs from Health Education England, 1 post for urgent care within the AED department and 1 post for planned care for the development of a PICC line service. Planned care funding authorisation will require formalising aligned to business case submissions.
- It is hoped that Advanced Clinical Practitioner posts will increase in number once their value is realised to assist with the medical rotas and to assist in departments within the Trust to continue to deliver high standards of care to patients working with medical, nursing and allied health practitioners.

6. Temporary Staffing

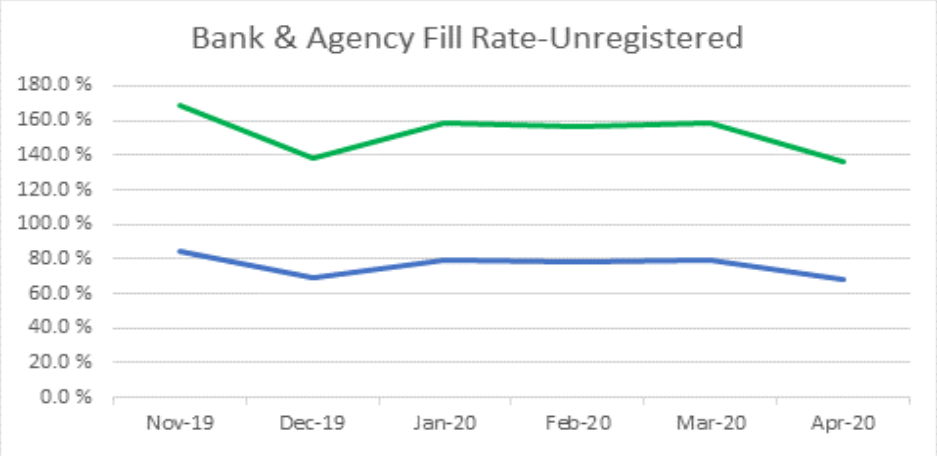
When staffing numbers fall below agreed staffing levels within an area there are systems and processes in place that supports deployment across CBU's to mitigate immediate needs. Managers have the tools to fill gaps with temporary staffing through the trusts collaboration with NHSP.

Graphs 6&7 demonstrate our trust current fill rates against requests.

Graph 6- Bank and Agency shifts filled – Registered



Graph 7- Bank and Agency shifts filled – Unregistered



Staffing & Skill Mix Reviews Update by Clinical Business Unit (CBU)

7. Urgent Care Staffing Establishment Review

In line with the Trust nurse staffing reviews the Clinical Business Unit (CBU) last completed a comprehensive establishment review and presented to Board in May 2019. The CBU used evidence based modelling (Safer nursing care tool –SNCT), professional judgement and 'Confirm and Challenge' desk top supportive review process alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

Staffing Reviews Undertaken by DoN/DDoN Nov 19 – April 20

- All ward based areas (See table 4)
- Seasonal planning reviews due to additional contingency capacity
- Accident and Emergency requirements has identified increase to establishment through winter funding however a full establishment review with peer review is planned to be re-scheduled within the scope of works required post Covid-19 pandemic.

Table 4 – Establishment review outcomes

Ward	Recommended change within establishment
15a	Nil
15b	X1 HCA per shift
7a	Nil
7b	RN and HCA uplift x1 per shift - business case required to support uplift
11b	Band 5 vacancy to create development band 6 role
EAU	Uplift band 6 budget from band 5 budget to increase total band 6 to 5.6wte
9a SSU	Nil
9b FESS	Nil
14b	Nil – see below comment
MDU	Nil

11b and 15b – Changes to be effected in budgets (to be funded within the establishment) – DoN approval planned before change is processed.

14b – Final agreement regarding the Hyper Acute business case is sort to understand the implications on current budget.

Highlights Nov-April 2020

- Building on keeping in touch methods i.e. Brew and Review
- Latterly there has been a month on month reduction in hours requiring temporary staff fill, via agencies and in some cases use of premium cost agency's Nov 19 – April 20 on established wards. Further improvement must be balanced by requirements to maintain contingency ward staffing.
- HoN role redeployed and interim cover provided by Head of Older Peoples Care until August 2020 and will then be reviewed.

- Coronary Care Unit (CCU) was moved out of Critical Care at the start of the Covid-19 pandemic; into a bay on 7a which is a General Medical/Cardiology ward. This was done with support from the cardiac nurses, coronary care nurses and senior staff who delivered teaching around clinical competencies needed to care for CCU patients. In addition agency staff with cardiac experience were block booked to deliver cardiac care and this will feature in the next establishment review pending a decision regarding the long term plan for this service provision.

Re-modelling and Transformation Work streams update

In this period the CBU has seen the successful opening/closing of additional areas including the discharge lounge and the development of this within the ward 1 template as a more permanent fixture. There has been a requirement to create additional roles and also use staffing resources differently including the redeployment and upskilling of many staff who have been supported with skills/knowledge training and with support from Boo Coaching. Evidence from both quality and safety metrics and operational performance demonstrate that new models of working are effective and some of the temporary changes have led to discussions around opportunities to work differently in future. These are feeding into the phase 2 COVID-19 recovery programme board.

A programme of work to redesign frailty pathways focusing on admission avoidance and re-direction of patients for assessment from Accident and Emergency has bene underway with the practitioners working in AED and EAU to commence early comprehensive geriatric assessment, gain a full and holistic assessment and enable timely discussion about complex decision making in collaboration with the geriatric and medical colleagues. The team are enrolled on ACP training and funding was approved for the Trust to join the Acute Frailty Network, which has been postponed due to COVID-19.

Previous discussions and approval in May 2019 focused on development of new roles and staffing requirements as part of considering new models of care aligned to the Trust and clinical business unit strategic direction. As part of this, the stroke nurse provision was improved and has been hugely beneficial in providing timely stroke assessment in extended hours. In addition, the rehabilitation ward has been increasing the ability to manage more acute patients and particularly during COVID-19, the AED has been reconfigured to provide red (covid) and green (non-covid) streams to protect patients. Ward 11A has been utilised as a medical ward and not a surgical ward during this time as has ward 14A at times, and the staff in all of these areas have been supported in adapting to meet the demands.

Initiatives and Innovation

A review and business plan are being undertaken for the development of a respiratory level 2 care bay – staffing model will need to be developed.

CCU provision having been stepped out of the critical care unit onto ward 7A for COVID-19. A decision is to be made regarding the permanent location of this and the staffing model agreed accordingly.

AED and the emergency/same day care pathways are under review with a view to developing more streamlined and appropriate pathways for patients and managing surges through planning activity with primary care and community colleagues – workforce will be incorporated within this review.

Recruitment and Retention:

- Listening events (Brew and Review) for, HCA and new nursing staff and revised preceptorship programme with planned review points and a celebration awards ceremony to recognise achievements.
- Revised Preceptorship programme launched.
- Presence at all Trust recruitment events.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level (see table 3):

Table 5-Urgent Care Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	4
Assistant Practitioner	14
Nursing Associate	12
Senior Healthcare Support Worker L3	6
Total	**36**

Over the next 12 month period the Trust, will aim to utilise apprenticeship levy funding to develop the current workforce using the existing pathways:

Additional Roles

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are 2 consultant nurses working on ACU, both are due to retire soon.
- There are currently 4 trained ACPs working within AED who have completed their Masters and RCEM speciality training.
- There is a trainee ACP working on ACU who was due to complete their Masters in May 2020, unfortunately this finish dates have been deferred to later in the year due to the COVID-19 pandemic.

Workforce Analysis

Registered Nurse Vacancy Position

The Urgent Care CBU has 104wte band 5 vacancies at the end of April 2020. This reflects the previous nurse staffing establishment uplift in May 2019 and requirements to staff seasonal contingency/COVID-19 areas.

Table 6 – Urgent Care Band 5 inpatient ward areas vacancy

Urgent Care

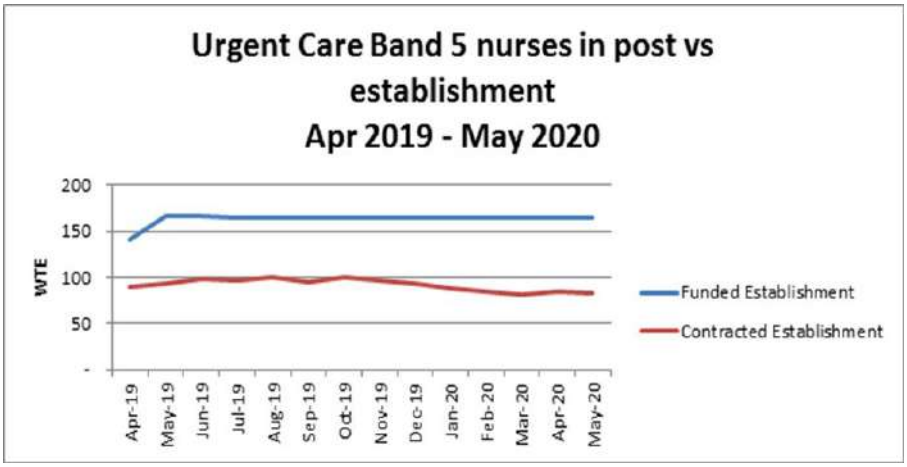
Nurse Band 5	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Funded WTE	185	220	220	220	220	220	220	220	220	220	220	220	221
Contracted WTE	126	134	138	136	135	128	134	127	124	120	112	111	117
Vacancy WTE	59	85	82	84	84	91	86	93	95	100	107	109	104

Table 7 below shows the age profile of our nurse band 5 workforce across inpatient areas in the Urgent Care CBU, currently reporting to have 13 staff members over the age of 55 (Trust inpatient total =30).

Table 7-Urgent Care Inpatient Band 5 age profile > 55yrs

Ward	56-60	61-65	66-70	>=71 Years
Emergency Assessment Unit	1			
FESS Ward				
Rehabilitation Ward ODGH	2			
Short Stay Unit	2			
Stroke Ward		1	1	
Ward 11B		1		
Ward 14B	1	2		
Ward 15A - General Medicine		1		
Ward 7A		1		
Total	6	6	1	0

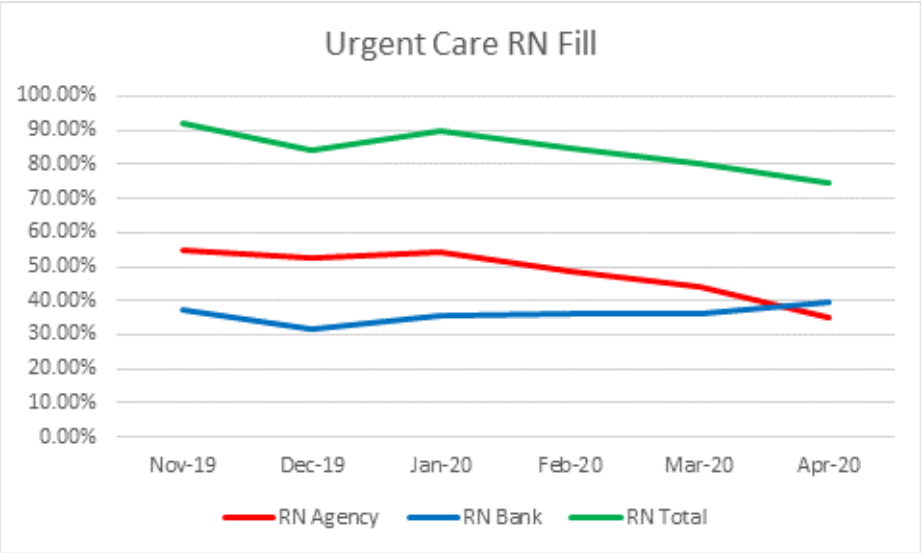
Graph 8 - CBU vacancy nurse **band 5 inpatient areas** position charts



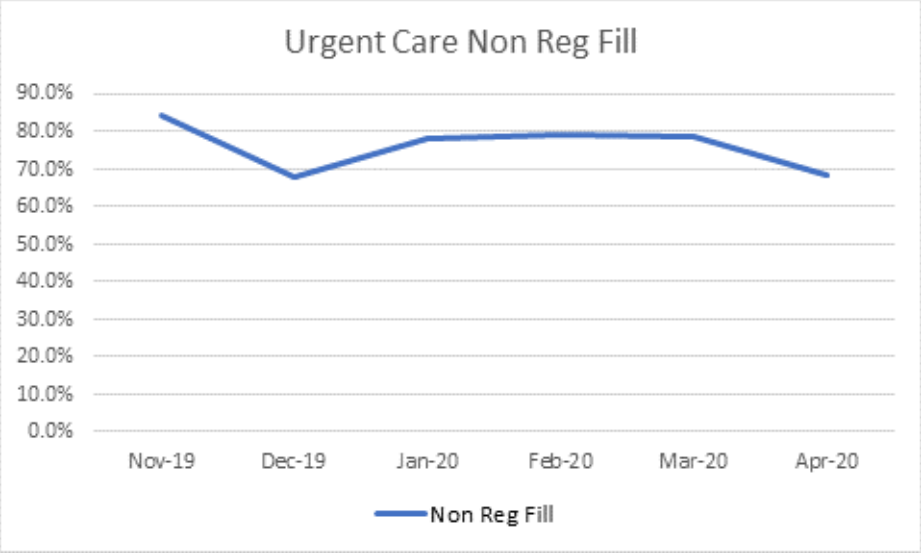
Temporary staff

There has been a reduction in agency use however this has been masked due to staffing requirement for contingency ward areas and use of agency staff. Of particular note there has been a significant reduction in the reliance on premium agencies and off framework agencies and a clear process is now in place for escalation to DoN, DDoN, should off framework support be needed only in the most exceptional circumstances. Agency block booking has supported areas with high level vacancy, until RN recruitment figures improve.

Graph 9 -CBU inpatient Registered shifts filled bank/agency



Graph 10- CBU Non Registered shifts filled by bank



8. Planned Care Clinical Business Unit -Staffing Establishment Review

In line with the Trust nurse staffing reviews the Clinical Business Unit (CBU) completed a comprehensive establishment review and presented to Board in May 20219. The CBU used evidence based modelling (Safer nursing care tool –SNCT), professional judgement and 'Confirm and Challenge' desk top supportive review process alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

Staffing Reviews Undertaken Nov 19 – April 20

- All ward based areas (See table 11)
- Seasonal planning reviews due to additional contingency capacity

Table 8 – Establishment review outcomes

Ward	Required change within establishment
14a	Increase band 6 from 0.74 to 1 wte Increase band 2 by 2.75 wte due to bank/agency spend.
11a	Nil
10b	Nil
ITU/CCU	Increase x1 wte HCA per shift
E, F & G	Band 5 vacancy to create development band 6 role
SIU	Review remains outstanding – booked for June 2020

Highlights Nov- April 2020

- Remodelling and transformation of the ACP workforce
- Remodelling ODGH site
- COVID-19 – impact on Theatres/CCU

Re- Modelling and Transformation work streams update

Theatres

A complete staffing review for theatres is required with peer review and is planned within the future staffing establishment reviews. The current risks relating to theatre are detailed on the CBU risk register and reviewed on a monthly basis. In addition we are working to develop new roles and models of working to assist in recruitment and retention of theatre staff

Recruitment and retention

- Listening events (Brew and Review) for, HCA and new nursing staff and revised preceptorship programme with planned review points and a celebration awards ceremony to recognise achievements.
- Revised Preceptorship programme launched.
- Presence at all Trust recruitment events.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level (see table 8):

Table 9 -Planned Care Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	3
Assistant Practitioner	4
Nursing Associate	12
Senior Healthcare Support Worker L3	7
Total	**26**

Additional roles

Nursing Associates and Trainee Nursing Associates

The CBU continue to provide training for our Trainee Nursing Associates and earlier this year welcomed the first qualified Nursing Associate into the Out Patient Department.

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

- There are currently 9 trainee ACPs all on different stages of the MSc.
- On the Southport site a SAU service was set up approx. 18months ago with a plan to staff this unit with ACPs. The unit has been successful in completing its KPIs to date and there is ongoing development planned within this unit. This service is currently staffed with 2 trainee ACPs who are both due to complete their Masters this year. There is also a bank ACP and Physicians Associate working within SAU.
- On the Ormskirk site is staffed with RMO covering 24hours, 7 days a week. This is complemented with an ACP team of 6. At present there are 3 trainee ACPs, 1 due to complete MSc in 2021, 1 in 2022 and 1 in 2023. Also there are currently 3 vacant posts which are currently being advertised. 1 vacancy was filled with a trainee ACP in June 2020 and is due to start in August 2020.
- In 2019 ITU was granted funding from HEE for 2 trainee Advanced Critical Care Practitioners, these practitioners began their MSc in 2019, due to complete their MSc in September 2021. It is proposed that these 2 posts will complement the ITU/ HDU rotas as it is hard to recruit medical practitioners with this area.
- In January 2020, an Advanced Orthopaedic and Frailty Practitioner were interviewed and are due to commence in post in June 2020

Workforce analysis

Registered Nurse Vacancy Position

The Planned Care CBU has 43wte band 5 vacancies at the end of April 2020. This reflects the previous nurse staffing establishment uplift in May 2019 and requirements to staff seasonal contingency/COVID-19 areas.

Table 10 – Planned Care Band 5 Vacancy

Planned Care

Nurse Band 5	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Funded WTE	213	228	228	227	227	227	227	228	228	232	233	232	233
Contracted WTE	181	183	184	180	179	176	180	187	186	192	190	190	190
Vacancy WTE	32	45	44	46	48	51	46	40	42	39	43	42	43

Predicted Vacancy

As with other CBUs, the ability to maintain the pace of recruitment to turnover presents a challenge which results in a continuous vacancy. The vacancy levels documented above include the acute ward areas, and critical care.

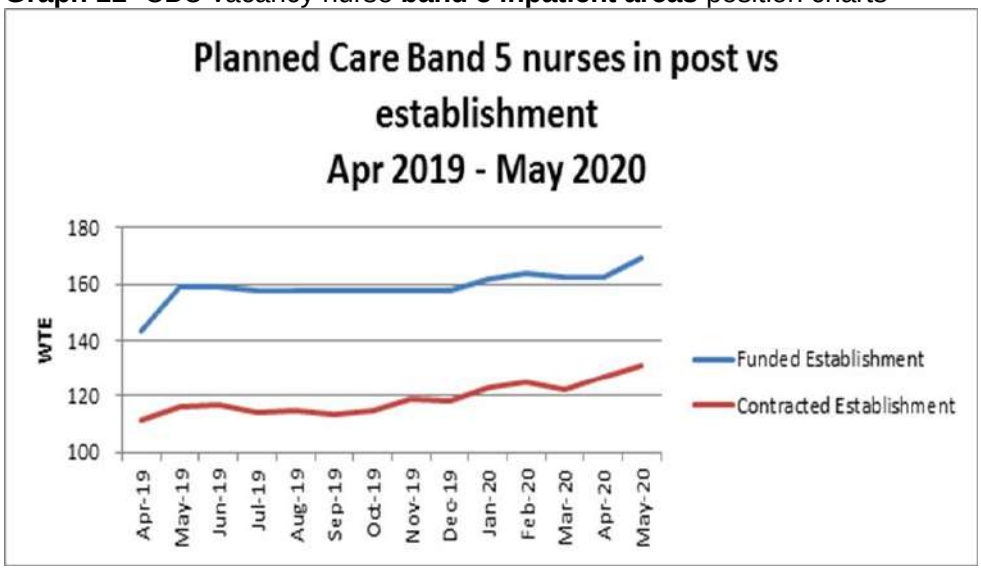
Working in collaboration with colleagues in finance and HR, the clinical business unit have committed to reviewing how by recruiting substantively to vacancy, turnover and mat leave, the need for bank and agency can be reduced. We will not get into a position whereby bank and agency can be eliminated until the clinical business unit reaches its agreed and planned recruitment figure. International recruitment will feature in this plan alongside retention and increase to our student numbers.

Table 11 below shows the age profile of our nurse band 5 workforce across inpatient areas in Planned Care CBU, currently reporting to have 17 staff members over the age of 55 (Trust inpatient total =30).

Table 11- In patient Band 5 age profile > 55yrs

Ward	56-60	61-65	66-70	>=71 Years
F WARD SURGICAL DAYCASE				
ODGH	3			
G Ward (EL Orthopaedics)		1		
ITU CCU	1	2		
Orthopaedic Rehab ward (H)	1			
Short Stay Surgical 10B				
Spinal Injuries Unit				
E Ward	1	1	1	
11A Surgical Ward	2	2	1	
Ward 14A	1			
Total	9	6	2	0

Graph 11- CBU vacancy nurse **band 5 inpatient areas** position charts

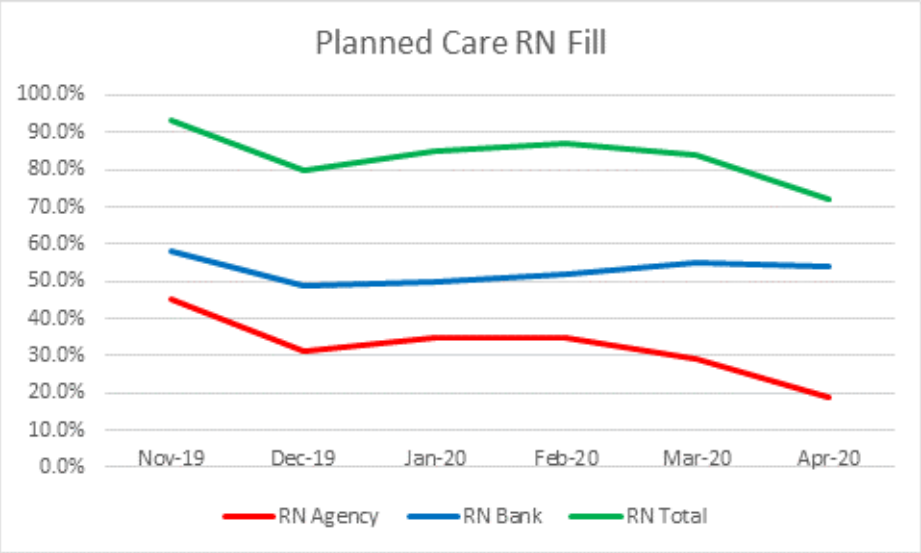


The establishment for band 5s increased in May 2020 as all of H Ward was funded (an additional 6.58wte band 5 RN's).

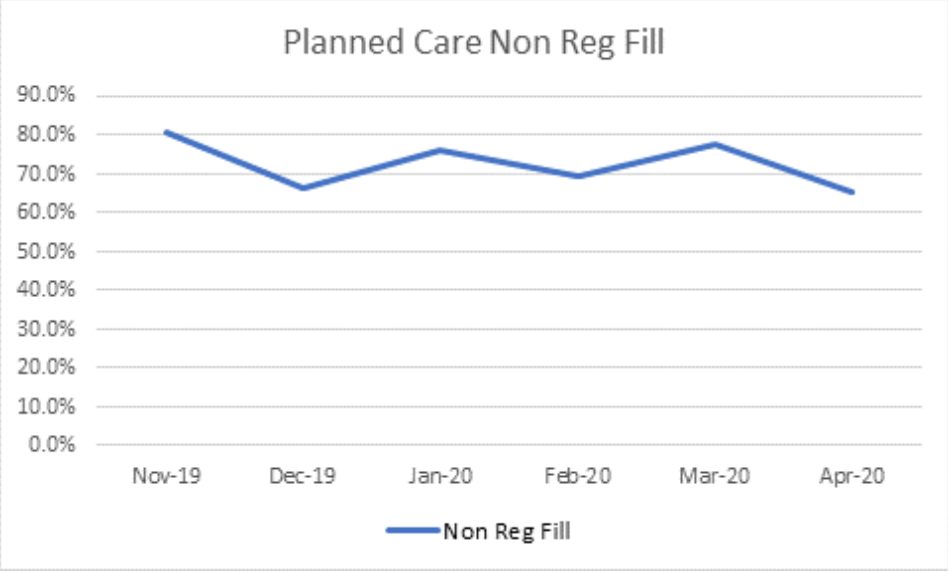
Contingency Area requirements

As part of contingency planning for winter, the clinical business unit altered the use of the elective orthopaedic ward and the staffing establishment. This resulted temporary staffing use. In addition the clinical business unit moved staff to Acute Adult ward areas to support the bed base and patient flow on the Southport Hospital site and moved staff to support the opening of ward 1 on a number of occasions and during the pandemic. Preparation for next winter is underway along with a review of the staffing plan for planned care utilisation of beds on the Ormskirk site not forgetting additional capacity to minimise the impact of temporary staffing.

Graph 12-CBU inpatient Registered shifts filled by bank and agency



Graph 13- CBU Non Registered shifts filled by bank



9. Specialist Services – (Children's Services and Maternity Services)

In line with the Trust nurse staffing reviews the CBU last completed a comprehensive establishment review and presented to Board in May 2019. To undertake the reviews, the CBU uses the Royal College of Nursing evidence based modelling, professional judgement and 'Confirm and Challenge' desk top exercise, alongside Model Hospital reviews and other key metrics including Care Hours Patient per Day (CHPPD), and acuity data including enhanced care requirements. Reviews are conducted in conjunction with clinical staff, finance, roster leads and business managers. Local staffing profiles are discussed as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons currently and, for future reviews, introduce alternative roles (i.e. Nursing Associates and Assistant Practitioners) and discuss predictive staffing models for 2020 – 2021 and beyond aligned to the trust workforce planning.

10. **Children's services**

This service encompasses general and specialist care provision across neonates to young people of 16 years with Cystic Fibrosis patients transitioning at 17 years, Diabetes patients transitioning at 18 years and young people with complex needs transition at 16 -17 year.

Workforce analysis

The paediatric unit does not currently always have supernumerary shift leader due to the flow of activity and acuity, however there is a coordinator identified and staffing is flexed to support and ward managers are supernumerary 5 days per week. Further review is planned to check the ratios against activity / acuity in preparation for the next staffing review.

Neonatal staffing is aligned to BAPM standards and within this establishment review a statement of case has been developed to support a number of changes including transitional care and options for implementation of a supernumerary shift coordinator to comply with BAPM standards.

Registered Nurse Vacancy Position

Table 12

Specialist Services

Nurse Band 5	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Funded WTE	53	62	62	62	62	62	62	62	62	56	56	56	56
Contracted WTE	63	65	64	61	62	63	66	67	66	66	66	64	61
Vacancy WTE	(10)	(3)	(1)	1	(0)	(1)	(4)	(5)	(4)	(10)	(10)	(8)	(5)

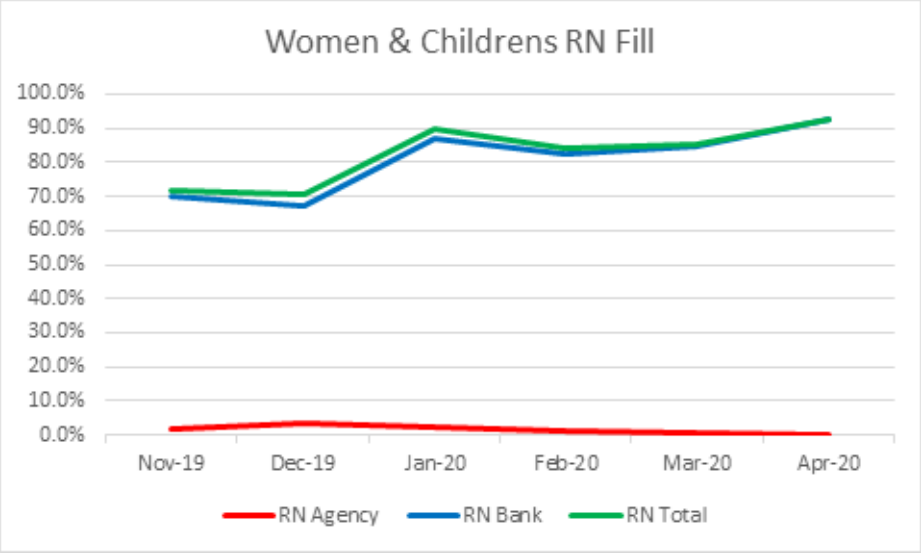
Historically there has been successful recruitment to vacancies, however in 2019 there were some problems due to tertiary hospitals offering all the students posts. The trust has now recently appointed 7.96 WTE for across the Paediatric Unit due to commence in post Mid-September 2020 after qualifying. This will put the unit up to full establishment.

The unit has very high levels of maternity leave over the last year and continuing this year and this has been supported via temporary staffing and NHSP.

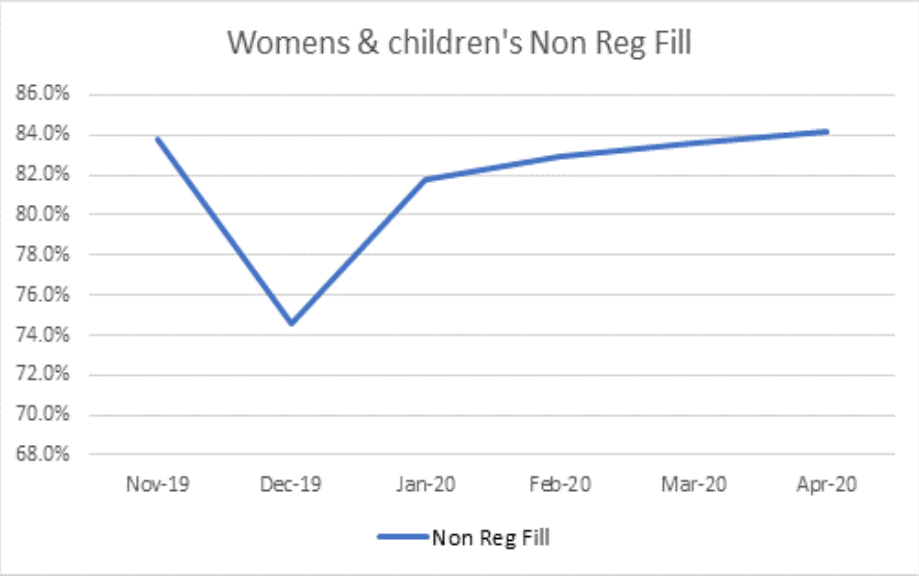
In response to COVID-19 and demands on medical staff, Paediatric A&E closed at night from the 6th April 2020, and this has allowed staffing to be managed safely with little reliance on NHSP along with reduction of activity during the pandemic. The patient flow is now starting to increase.

Matron meets with the Ward leaders on a weekly basis to discuss staffing for the week. Ward leaders are expected to review staffing on a daily basis. The weekend is always checked on a Friday and plans in place if staff are off sick and unsure whether resuming.

Graph 14 CBU inpatient Registered shifts filled by bank and agency



Graph 15 - CBU Non Registered shifts filled by bank



Staffing is reviewed in the twice daily safe staffing huddles and Matron meets with Band 7's on a weekly basis to discuss staffing for the week and the ward managers review on a daily basis. The weekend is always checked on a Thursday.

Table 13 -Children's Services Apprenticeships Nov-April 2020

Advanced Clinical Practitioner (Degree)	2
Total	**2**

In response to the staffing review in December 2019, it was agreed to increase the number of Band 6 staff and slightly reduce Band 5 in order to ensure senior cover across all areas 24/7.

Advanced Nurse Practitioners (ANP) Advanced Clinical Practitioners (ACP)

- 5 trained ACPs working within Paediatric AED (1), ward based (3), neonates (1).
- There is 1 trainee ACP working within Paediatric AED who has completed her MSc and is due to complete their specialty competencies in August 2020 and 1 bank ACP also working within AED. All of these staff works alongside the Paediatric medical staff.

11. Maternity Staffing Review For the Period July 2019 to April 2020 (inclusive)

In accordance with requirements for NICE standards for Maternity staffing 'Safe Midwife Staffing in Maternity Settings' (2015), and Clinical Negligence Scheme for Trusts, a bi annual report should be submitted to the Board to provide assurance that the midwifery establishments are safe and that staff are able to provide appropriate levels of care to women and babies. The last staffing review was presented in August 2019 for period January to June 2019. Therefore in order to incorporate the data within the timeframe since the last presentation to Trust Board, this review will cover the above period.

Birth Rate Plus Acuity assessment to calculate the required establishment

A Birthrate Plus assessment (BR+) was last commissioned in February 2019. BR+ is a framework for workforce planning based upon an understanding of the total midwifery time required to care for women and includes a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings (2015), and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetrics & Gynaecology (RCOG).
The calculations for staffing are attached in Appendix 1.

The outcome of the assessment identified the following:

Table 14- Midwifery establishment

Midwives	Current Establishment	BR+ Recommendations	Variance
Clinical Midwives	92.32wte	93.77wte	**- 1.45wte**
Non Clinical role/ Specialist Midwives	6.00wte	8.44wte	**- 2.44wte**
Total	98.32wte	102.21wte	**- 3.89wte**

Table 15- Support Worker establishment

Maternity Support	Current	BR+	Variance

Workers	Establishment	Recommendations	
Band 3/4	6.84wte	9.38wte	**- 2.54wte**
Band 2	10.40wte	12.00wte	**- 1.6wte**
Total	17.24wte	21.38wte	**- 4.14wte**

For this reporting period a 'table-top' exercise has taken place based on the criteria for birthrate plus for this reporting period with no change to previous report. Therefore the ratio of births to midwives is:

Table 16

Birth Rate Plus Ratio	Recommended ratio of births to midwives is 1 Midwife to 26 births

The overall ratio for number of births to number of midwives for Maternity Services are not directly comparable to other Maternity providers because of the local factors involved.

In view of 'Better Births' recommendations "Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally." This is a shift from our more traditional model of midwifery care to a more flexible team approach with the focus on the women and their families. In response to this Maternity has developed a new workforce model which will require an organizational change and need financial support to implement. An options appraisal was presented at Performance Review Board and Hospital Management. Following this the Director of Nursing has commissioned an external assessment by Maternity specialists in NHSI to evaluate options and benchmark against other provider before making recommendations to the Board.

Action Plan to Address Findings from BR+

An action plan has been implemented to address the findings from the BR+ audit because deficits in staffing levels have been identified. This is attached in Appendix 2.

Planned versus actual midwifery staffing levels including evidence of mitigation /escalation for managing shortfalls

- Roles and responsibilities for maternity staffing are outlined in the Maternity Services Standard Operating Procedure (Number 52) for Staffing Levels and Maternity Services Standard Operating Procedure (Number 53) for Maternity Escalation
- Maternity has roster check and challenge meetings to ensure effective and efficient use of the roster against E Rostering KPI's and completing of the daily safe staffing process.
- Fill rates are published monthly with Maternity consistently monthly over 90%
- Staffing is discussed as part of the Delivery Suite Shift Coordinator hand over as they have the overview of daily staffing levels. This takes place twice a day, and ward dependency, acuity and overall staffing ratios/ gaps are discussed.
- Staffing levels and staffing issues are reported via DATIX and reviewed as part of the Patient Safety Meetings

Supernumerary Status of the Delivery Suite Shift Coordinator

The delivery suite shift coordinator is supernumerary to enable them to fulfil their role, which is pivotal in providing effective leadership, clinical expertise, facilitating communication between professionals and overseeing appropriate use of resources. The shift coordinator was rostered as supernumerary 100% of the time. Compliance with supernumerary status was 99%. This was because there were some occasions where there has been a need for the coordinator to care for women for short term (less than 3 hours).

Percentage for Provision of One to one Care in Labour

Maternity services aim to achieve 100% 1-1 care in labour and this is monitored via the Maternity Information System and where this cannot be provided a DATIX incident report is completed which is recorded as a 'red flag'. During the reporting period there has been one occasion when one to one care could not be provided. This was because the midwife was required to scrub for an emergency caesarean section. This was an anticipated risk following review of the theatre provision and has been risk assessed.

Staffing related incidents and Red flag indicators

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. Maternity Services Standard Operating Procedure for Maternity Services Staffing reflects the recommended reporting guidance. This data is collected via the DATIX incident reporting system and monitored via the Maternity Dashboard. All red flag incidents are also discussed at the weekly Patient safety Meeting and cross referenced with clinical incidents. For this reporting period there were 20 logged incidents in relation to maternity staffing.

Midwifery Red Flag Indicators

Table 17

July 2019 – April 2020	
Midwifery Red flag	**Incidents**
Delayed or cancelled time critical activity	5
Missed or delayed care (delay of 60 minutes or more in washing and suturing).	
Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).	1
Delay of more than 30 minutes in providing pain relief or medication	
Delay of 30 minutes or more between presentation and triage.	
Full clinical examination not carried out when presenting in labour.	
Delay of 2 hours or more between admission for induction and beginning of process.	13
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	1 (explained above)

The red flag data demonstrated an issue with '*Delayed or cancelled time critical activity' (5)* and '*Delay of 2 hours or more between admission for induction and beginning of process' (13)* These related mainly to two periods of time in September and November when there was delay in commencing the induction process due to increased acuity and activity in the maternity unit. There were no patient safety issues identified.

Highlights

- Senior Midwifery oversight until 8pm and at weekends has been introduced to support staff by having a 'helicopter view'. This enables efficient response to any staffing shortfalls, unpredicted demands on the service and any other concerns that may arise.
- Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting
- An acuity tool has been implemented on Delivery Suite and the Maternity Ward to monitor activity and patient acuity against midwifery staffing. This is still being embedded.
- During the reporting period the maternity unit did not close

- During the reporting period the home birth service was temporarily suspended from 30th March 2020 to 18th May 2020, due to staffing levels and effects of COVID
- In response to COVID staff in the 'at risk' groups have been supported either by working in non-patient facing environments, working from home or being shielded. Whilst Sickness absence rates increased to 14-15% this has been managed well with the support of staff working flexibly or on NHSP. Sickness absence rates are now demonstrating improvements.
- Maternity Services does not experience any difficulties recruiting staff with high numbers of applicants for posts. Turnover rates are currently less than 1% for this reporting period

Next Steps

- Confirm next steps regarding Continuity of Carer with Director of Nursing & Midwifery COC Workforce
- Liaise with Cheshire & Merseyside Local Maternity System regarding central funding for Birthrate Plus assessment in 2020
- Embed the intrapartum/ward acuity tool

12. Conclusion

. As with previous reports, the Trust continues to carry a number of nursing vacancies. This is reflected in the Trust Board Assurance Framework (BAF) and the Clinical Business Unit's Risk Registers.

Reviews of staffing numbers and skill mix will continue to be ongoing with the next Bi-annual staffing review commencing July 2020. The trust will incorporate outcomes of national patient acuity tools with future establishment reviews and proposed changes will be based on triangulation of acuity, current quality indicators and outcomes and professional judgement, whilst taking into account any available national guidance.

13. Recommendation

The Board is asked to receive the report, support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.

Finally, the Board is also asked to recognise and commend the work and efforts of the entire nursing and midwifery workforce who are committed to, and continue to deliver safe and effective care whilst working in the recent challenging environment.

Report authors:

- Claire Harrington – Deputy Director of Nursing
- Carol Fowler – Assistant Director of Nursing – Workforce

In collaboration with:

- HoN- Stephen Mellars
- HoN- Grace Delaney Segar & Megan Langley
- HoM- Lynne Eastham

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**22 JUNE 2020**
LEAD:	**MR DAVID BRICKNELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The extreme risk relating to clinical training is to be the subject of detailed and assertive executive action in the short-term, particularly in the light of the Health Education England (HEE) visit in August.

ADVISE

- Whilst significant progress has been made in medicines management, there is still work to be done in the ward culture of recognising the importance of its detailed application.
- Good analysis continues to be done in the Serious Incident Review Group (SIRG) process, but there is a need to develop the application of lessons learned, and specifically clinical involvement.
- Despite the pressures of the pandemic, the Cancer Team had been outstanding in keeping in touch with cancer patients and optimising their continuing treatment.
- Significant improvement had been made in relation to the Neck of Femur mortality, but improvement in meeting the 36 hour treatment target still required work.

ASSURE

- Progress is being made in addressing the extreme risk of staffing levels. Overseas recruitment is going ahead and the influx of student nurses and their recruitment to establishment in the near future will have a significant impact.
- The organisation is in control of the Covid crisis at its current level. A staff risk assessment report will be presented at the next Board meeting.
- The QIAs will be followed up to ensure that the outcome of the assessment was matched in the experience of the patients.
- The figures for Acute Kidney Injury (AKI) mortality have not improved as much as the general HMSI figures and a focussed action plan is in place which will be reviewed by the Committee in 3 months' time.
- The new Perfect Ward app is to be rolled out across the organisation and will provide real time data on all aspects of ward performance and will bring together and improve a number of existing monitoring and auditing activities.
- The Freedom to Speak Up Annual Report reflected a significant improvement to this aspect of staff involvement, and an increasingly trusted forum for concerns.
- The mandated annual audit of Infection Protection and Control will tie in with existing arrangements, particularly as they have been enhanced through the response to Covid.

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

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

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB116/20a**	**FOI Exempt**	**NO**
Report Title	**QUALITY PRIORITIES PROGRAMME UPDATE**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The purpose of this report is to provide the Board with an update on progress against the Trust's Quality Priorities.

Executive Summary

This report provides an overview of the progress of the Quality Portfolio in the context of the Coronavirus pandemic and the Trust's transition into "Phase Two Response to Covid" in May 2020.

Section three of the report provides a summary of the progress up to 19th May 2020 for each of the quality priorities:

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

Recommendations

The Board is asked to receive this report .

Previously Considered By:

✓ **Quality & Safety Committee**

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Jo Simpson	Jo Simpson

Quality Improvement Programme Update June 2020

1. Purpose of Report

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

2. Quality Priorities

The "Business with Covid" Programme is now underway across the Trust, working with CBUs to plan for recovery whilst incorporating National guidance to ensure our staff and patients feel safe and this has meant that some resource can now be refocussed on the Quality Programmes whilst others are still redeployed; where possible, meetings with programme and work stream leads have been conducted to reinstate activity in the case of Deteriorating Patient Programme and the Medicines Management Programme. Putting the work into context, following the pandemic, has meant that clinical leads have reviewed the approach to appropriate activity required to support the Quality Improvement Programme in the light of the changes, and transitions are now beginning. The Older Peoples Care Programme has identified new clinical leads in order to support a review of timescales and priorities.

Last month the report reflected on the need to review timelines and milestones, and work is now also underway to ensure the measures are correct and reflect progress on the activity taking place. These measures are not readily available and will take time to transition. The aim will be that this report offers assurance against the activities being undertaken by the project teams.

In the case of the Deteriorating Patient Programme, a complete review of the activities planned has taken place and new indicators will be required to evidence progress against that journey. For the Medicines Management Programme the CQC Must Dos and Should Dos remain the priority.

Infection Prevention and Control has taken centre stage during the pandemic and the understanding and engagement with the team has shifted considerably as a direct consequence. It will form an integral part of the recovery plan. The aim is to ensure all the Quality Priorities run as a continuous thread throughout the Business with Covid programme.

3. Quality Priorities Implementation Plan – Update Report, June 2020

Medicines Management Optimisation Programme	*To deliver a safe and optimum acute medicines management system from admission to discharge, which will achieve a CQC Rating of 'Good' and Model Hospital metrics in line with or improved against peer median measures by December 2021*

Risk Register

2122 Medicines Management.

If the trust cannot guarantee Safe and Secure Handling of Medicines and Clinical Pharmacy Service then there is a risk of patient harm through lack of timely medicines reconciliation, supply of critical medicines to patients, correct prescribing and administration of medicines and risk of patients going home without the correct take home medication.

The risk has been downgraded from extreme to high in May 2020

Summary dashboard

The Committee is to be made aware that due to other priorities, BI is not currently running the data for the Quality Priorities Dashboards. Additional work is still required to finalise the Medicines Management Dashboard.

0 medication errors Resulting in moderate harm or above	**100%** Ward expiry date checks completed	**65%** Medicines Reconciliations Completed on Wards	**100%** TTOs Dispensed to Patients who have been Discharged

Planned activity for Quarter One (April to June 2020)	**Progress Update (June 2020)**
Our aim by the end of Quarter One is to be fully compliant with the 'Must Do's' from the CQC report. This includes; no expired medications, no TTOs on wards over 24 hours, yellow date labels for oral liquids, CD Policy embedded and followed. In order to achieve this aim we will:	**1. Overview** **CQC Must Dos and Should Dos** Across Medicines Management the compliance with the CQC must do actions is being maintained throughout the management of Coronavirus Pandemic. Weekly Work Stream meetings have recommenced for 'Safe and

1. Undertake regular and consistent expired medicines and temperature checks 2. Undertake regular and consistent Medicines Ward Trolley Audit 3. Ensure regular checks are undertaken by Pharmacy Ward Assistants 4. Ensure that oxygen is prescribed and administered appropriately, and that Oxygen cylinders are stored securely 5. Ensure that a process is in place and is communicated across the Trust for Patients self-administration of medicines. 6. Document and share key Roles and Responsibilities within Medicines Management 7. Undertake a comprehensive and structured Medicines Management communications campaign to ensure that Trust has a clear vision for Medicines Management that understood by everyone. 8. Introduce 'Top 10 Medicines Management' Lanyard Cards 9. Compliance to Controlled Drugs Trust Policy	Secure Handling of Medicines'. Sessions have been tabled in June to focus on the following areas to embed the CQC Action Plan: W/c 1st June Work Stream Regroup and Review W/c 8th June Communications Plan – SSHM Information Wall Board W/c 15th June Roles and Responsibilities Document W/c 22nd June TTOs and Discharge Process (developing roles of band 5 Technicians to counsel and reconcile medicines at discharge) W/c 29th June Patients self-administration of Medicines **Data Intelligence: The Perfect Ward** The introduction of the Monthly Matron's Checklist on The Perfect Ward is providing the project team with smart, reliable information with which to inform compliance levels, progress and areas requiring improvement. The data is to be triangulated with the information collated by the Pharmacy Assistant Technical Officers to provide additional insight. At present only 9 Wards are live on The Perfect Ward but this will be increasing to all 33 Clinical Areas over the next two months. (Only 11 Clinical Areas had been included in audits pre-Covid-19.) **2. Compliance Audits – Expired Medicines, Temperature Checks, Ward Trolleys** Covid-19 Phase 1 pressures have had a negative impact on compliance levels. The Trust's Quality Matrons are now returning to the wards to support the teams with their improvement plans to reverse this trend. Additional Pharmacy Assistant Technical Officers are also being trained to increase the number of staff undertaking checks. • 100% of Medications in date in Ward Cupboards (9 wards) • 100% of Medications in date on Resus & Deteriorating Patient Trolleys (8 wards) • 100% All IV fluids in date on ward (9 wards)

	• 67 % of CD checks have been completed in line with the policy • 67% of Medicines in Drugs Trolleys are up to date (9 wards) • 56% of wards were compliant with Daily Clinical Room and Fridge Temperature checks (over previous 30 days.) (9 wards.) Deep dive into Perfect Ward data triangulated with Pharmacy ward audits will confirm which areas require additional support. Work with Pharmacy Assistant Technical Officers is planned to understand whether issues are promptly escalated and correct actions taken (for example if a fridge is out of range is it escalated and reported on Datix.) **3. Ward Pharmacy Assistant Technical Officers** The Pharmacy Team is in the fourth week of a PDSA for a revised and extended role for a Band 4 Pharmacy Ward Technician on Ward 9A (Short Stay Unit.) A SOP based on the success of the Band 5 role on Ward 14A is informing the trial which it is hoped will be extended shortly onto FESSU. The extended role includes the entry of medicines into the E-Discharge system to support timely and accurate ordering of inpatient and discharge medicines system and management of bedside lockers. The new role of the Band 5 Technicians is being developed to include patient counselling and reconciliation of medicines at discharge. There is discussion as to whether temperature and expiry date checks can be added into the role of the Band 4 Technician. To reiterate on last month's update on levels of recruitment against the Business Case: three of the six Ward Pharmacy Technician posts have been recruited (two are in post, one to commence in July 2020.) The remaining unfulfilled posts are being addressed through a programme of upskilling and succession planning for future recruitment in spring

	2021. **4. Oxygen** Clinical audit has demonstrated that there is an improvement in oxygen prescribing and that there has been a change from recording administration on the drug chart to recording the flow rate is on VitalPac which then provides the dashboard. This informs the Trust's new Oxygen Dashboard (for COVID) which provides assurance for the CQC's recommendations that oxygen therapy is correctly: prescribed, administered and signed for. The dashboard is monitored centrally by the Medical Lead officer and is also present on each ward. Its use will be a key feature of the Trust's emerging recovery plan. The dashboard links into Medway permitting a central view of all patients being administered oxygen, from this, spot checks and audits can be conducted for assurance of compliance to correct practice. **5. Self-Administration of Medications** A meeting has been tabled for 29th June in order to confirm actions to embed a process for the self-administration of medication. **6. Roles and Responsibilities** A meeting has been tabled for 15th June to confirm the process and actions required to develop a Roles and Responsibilities Document to robustly deliver the Safe and Secure Handling of Medicines. The work currently being undertaken to develop the Ward Pharmacy Technician roles will be incorporated into the document which may be

	subject to iterative change, dependant on the roll out of the Band 4 & 5 template across the wards. **7. Controlled Drugs** The Perfect Ward Matron's Checklist for May has reported that 67% of Controlled Drugs checks have been completed daily, in line with the Trust's CD policy (last revised and relaunched in February 2020.) The latest quarterly Controlled Drugs Audit Report will be presented to the July Medicines Safety Committee with any issues escalated to the Drugs and Therapeutics Committee (DTC.) The DTC Annual Report including assurance on compliance to policy will be submitted to the July Quality and Safety Committee. **8. Communications Campaign** The Safe and Secure Handling of Medications project group has this week finalised the content of a large, corridor infographic of best practice for the delivery of the Safe and Secure Handling of Medicines. This is to be further developed by a graphic illustrator before going to print. It will be used to launch the Medicines Management Comms Campaign. Discussions are ongoing with the Trust Comms Team as to the best methodology to get across key messages going forward to replace plans for drop in sessions. **9. Additional Project Updates** **Omnicell: Automated Ward Storage** Final walk arounds are taking place on Thursday 18th June in A&E and

	ITU with Omnicell, from which a risk assessment will be produced with Clinicians, Estates and the Fire Safety Teams. **Workforce Development:** A three month QI Training Programme for Pharmacy has commenced for Pharmacy and Nursing with the objective of developing a QI culture for Pharmacy and Medicines Management.
Recognition and Care of the Deteriorating Patient Project	*To reduce the average time for the recognition, review and treatment of the deteriorating patient by April 2021.*

Risk Register

Existing risks regarding mortality, risks to be reviewed in May 2020 new risk to be considered relating to Quality Priority.

Summary dashboard

The Committee is to be made aware that due to other priorities, BI is not currently running the data for the Quality Priorities Dashboards.

83.6 Rolling 12 Month HSMR (January 2020)	**101.11** Rolling 12 Month SHMI (Feb 2019 to Jan 2020)	**63.60%** On Time Observations (VitalPac - Trust Level)	**113.5** Local HSMR for Acute Renal Failure (AKI)

Planned activity for Quarter One (April to June 2020) Our aims for Quarter one had been to establish a baseline and standardise the Trust's approach to recognise and care for deteriorating patients appropriately. In the context of Covid-19 Pandemic and the required realignment of strategy, activity and redeployment of resource, the programme has	**Progress Update (June 2020)** The project has been subject to review in line with the impact and learnings from Covid-19 Phase 1. The aim and objectives of the project have not changed apart from the removal of mortality related activity which is not within the scope of the Recognition and Care of the Deteriorating Patient.

not been progressed as per the original timeline. A high level gap analysis has been undertaken and as a result Learning from Deaths and associated Mortality activity have been removed from the scope of the project. The new project format addresses the same objectives as before, but with a revised structure for delivery: 1. Identification of Risk Groups 2. Escalation Planning 3. Physiological Observation 4. Senior Oversight 5. Clinical Pathways	Resources are currently focused on the ratification of changes to the project through the governance process, the revision of milestones, the transfer of projects to Smartsheets and the organisation of new meetings. **1. Observations and Escalation** Last month it was reported that the progress on the 'Observations and Escalation' work stream had been greatly impacted by staff availability and that project activity had temporarily ceased because of Covid-19. Meetings have now recommenced and a revised plan for training and process redesign is being submitted to the Quality Team. Headlines of the plan will be included in the July report. There has finally been minor progress on the outstanding request to System C to move from 30 minute to hourly observations for patients with a NEWS2 score of 5 and above. Once the system has been reset, premature 'overdue' and 'breach' alerts will cease and performance will be accurately represented in the monthly compliance reports. At present, reporting is negative skewed and cannot be used to monitor progress. The safest ratios of staff, patients having observations taken and patients appropriate for removal from protocol will be discussed at a **Deteriorating Patient Workshop in July**. Nursing staff will map the process for removal of appropriate patients from protocol. Embedded best practice will in turn enhance the targeted approach to improve NEWS2 compliance. **2. Clinical Pathways (Formerly "Correct Pathways of Care")** The focus for the **Clinical Pathways** work stream will continue to be Acute Kidney Injury (AKI). Advancing Quality Alliance (AQUA) has

	reported AKI performance against Trust target as an improved to 44.2% for April 2020 over 40.7% for March 2020. Workstream activity will continue to be focused through the seven Advancing Quality Alliance (AQUA) clinical performance measures: • Urine dipstick test within 24 hours of 1st AKI Alert **38.6%** • Stop ACE inhibitors and ARBs within 24 hours of 1st AKI Alert **94.1%** • Serum creatinine test repeated within 24 hours of the 1st AKI Alert **73.3%** • Ultrasound Scan of urinary tract within 24 hours of 1st AKI Alert **17.5%** • Specialist Renal or Critical Care Discussion within 12 Hours of 1st AKI 3 Alert **21.9%** • Written self-management information prior to discharge **0.0%** • Pharmacist Medication Review within 24 hours of 1st AKI alert **31.1%** The first weekly meeting has taken place with work stream clinical lead, Dr Henry Gibson at which activity and blockages were reviewed against the seven measures. Milestones will be confirmed in the July report.
Care of Older People	*We aim to improve the care of older people by reducing length of stay, reducing re-admission rates and reducing the recorded incidence of harm from care of older people by the end March 2021*
Risk Register – (2173 Requirement to Improve Older People's Care) ***If the quality of care delivered to older people does not improve in Southport and Ormskirk NHS Trust, then patients will experience harm and poor outcomes impacting negatively on their quality of life, independence, function, experience and recovery. The specific risks include: Care of people with Dementia or Delirium, Falls risk reduction and management of falls, Nutrition and Hydration including NG Tube Feeding, Mouth Care, Continence care, End of Life Care, Deconditioning, Discharge Quality, Discharge Pathways*** - Risk has been downgraded from extreme to high in May 2020	

Summary dashboard			
67 falls across the Trust (threshold 71)	**67.9%** of patients received a MUST screening assessment within 24	**66.6%** of appropriate patients having cognitive awareness assessment	**97.6%** of patients have a falls risk assessment and a falls care plan

	hours of admission (target 95%)	(target 95%)	in place (target 95%)
Planned activity for Quarter One (April to June 2020) Our aim by the end of Quarter One is to continue to progress planned actions to improve the quality of care for older people across the Trust. In order to achieve this aim we will: 1. Approve of the revised staffing mix for the Frailty Model 2. Agree the Action Plan for the in-patient Frailty Model 3. Agree the Action Plan for the Enabling Environment work stream 4. Approval the Care Home Education Programme by Urgent Care Delivery Board 5. Falls equipment procurement completed 6. End of Life TNA completed and Ward Accreditation Scheme developed 7. Dementia and Delirium Action Plan developed 8. NG Feeding pathway and competency approved by Clinical Effectiveness Committee		The Covid-19 pandemic response has meant that almost all of the work on Older People's Care has been halted as lead clinicians were redeployed. It has however provided an opportunity for the leads to review the work as a whole to ensure the workstreams carried forward are more manageable, and still valid and appropriate to this forum. Progress has been made though in identifying different leads for the following workstreams; *Enabling Environment* *Home First* *Nutrition & Hydration* *Mouth Care* *NG Feeding* *Dementia & Delirium* *Quality of Life Feeding* *Spinal Fracture (pending)* Actions to progress the individual projects will now be taken up with those leads, supported by the PMO, to strengthen governance and reporting of progress. A smartsheets project plan will document the activity required and provide reports in a digital format as new ways of working are embedded across the trust. 1. **Approve of the revised staffing mix for the Frailty Model** Funding has been secured for the Frailty Network and places have been secured on the Acute Frailty Network for the Trust – progress is currently on hold due to COVID-19.	

	2. Agree the Action Plan for the in-patient Frailty Model Frailty modelling is now a key priority in the work progressing as part of Business with COVID. **3. Agree the Action Plan for the Enabling Environment work stream** This work area will be led by Therapies and is scheduled to be completed in draft by the end of quarter 1. Meetings will be reconvened to support this Workstream later in June with the newly identified lead. **4. Approval the Care Home Education Programme by Urgent Care Delivery Board** This work has had to be placed on hold due to the lack of movement permitted under COVID 19 guidance. **5. Falls** Falls procurement completed. Meetings will be reconvened to support this Workstream later in June. 6. **End of Life** End of Life project will no longer be an integral part of this programme, work in this area is being picked up by the End of Life Strategy Group. **7. Dementia and Delirium Action Plan developed** On track to be completed at the end of Quarter 1. Meetings will be reconvened to support this Workstream later in June with the newly identified lead.

	8. NG Feeding pathway Meetings will be reconvened to support this Workstream later in June with the newly identified lead. **In addition** Discharge Quality Workstream has been removed from the Older People's Care Workstream and now sits with Director of Nursing as a separate piece of work As part of the excellent work done by the trust in response to the pandemic the Older People's Care representatives have made a significant impact; • Redeployed a geriatrician into the community to work up the admission avoidance element of the Frailty Model • Ordered and due to take delivery of Falls alarms which will shortly be rolled out on the wards • Started rolling out Mouth Care Matters on Ward 11B to maintain momentum • Submitted a bid for a sensory garden as part of the Dementia and Delirium work stream • An Advanced Orthopaedic Practitioner has commenced in post on ward 14A • Ward 14a has also begun trialling new documentation to better manage the uses of appliances and braces as they relate to skin care.
Infection Prevention and Control	*We aim to pro-actively prevent, reduce and manage hospital associated infections*

Risk Register – (2210) Covid-19 - Provision of Consumables, Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting lack of PPE for staff. Initially extreme risk now downgraded to High. Risk to be reviewed in May 2020, new risk to be considered relating to Quality Priority

NHSE /I Infection Prevention Control Board Assurance Framework has been competed, although this framework is not compulsory it will be used as a source of internal assurance and support the Trust to maintain quality standards. A summary report will be provided to Quality & Safety Committee in June 2020.

Summary			
100% compliance with hand hygiene policy	**Less than 100%** compliance with bare below the elbow policy- with only a few exceptions	**100%** of patients who have a history of MRSA colonisation were appropriately isolated on admission	**Zero** MRSA colonisation acquisitions

Planned activity for Quarter One (April to June 2020)

Our aim by the end of Quarter One is to improve our IPC compliance.

In order to achieve this aim we will:

1. ANTT training needs analysis completed
2. ANTT embedded into the role specific mandatory training programme
3. Complete HEAT inspection and implement learning through planned quality improvement activities
4. Cannula Value based procurement completed

Progress Update (June 2020)

Our IPC team have been focussed on leading and supporting the Trust response to the Coronavirus recovery planning. Therefore none of the specific quality improvement activities have been initiated.

1. **ANTT training needs analysis completed**
   ANTT TNA Completed

2 **ANTT embedded into the role specific mandatory training programme**
   ANTT training has been established and e-learning is now available on the trust intranet and via Practice Education Facilitators but it has not yet been embedded into the mandatory training programme due to technical issues which require addressing.
   NB: The Blood culture contamination rate at 4.4% is the lowest rate

	in the last 12 month period. Wards are identified where the percentage of contamination is higher and this informs a response to those areas. Bare below the elbow checks had to be done on an ad-hoc basis and some staff were seen wearing wristwatches. No percentage figure was possible due to the nature of the checks undertaken. 3 **Complete HEAT inspection and implement learning through planned quality improvement activities** –This was not done in April due to COVID 19 and the initial requirement for a full team to undertake the check. The audits have now been reinstated as an IPC inspection with a smaller team, just a matron with an IPC nurse- using aspects of the National tool , looking at all areas of the ward such as sluice, kitchen etc. – if a ward registers low scores on any one area then they are re-inspected within 2 weeks. This monthly inspection is now more meaningful, and will demonstrate good practice as well as highlighting the challenges and as a consequence encourage greater clinical buy in. Ward based hand hygiene audits were limited due to restricted movement between wards under COVID guidance but those that were completed (6 wards) demonstrated 100% compliance. Next month wards are being asked to monitor their own areas to avoid unnecessary movement between them. Wards are being asked to identify a hand Hygiene ambassador on each shift and that individual can audit and log and record any breaches to support the IPC compliance work. The IPC team continue to proactively support the Trust in its Business with COVID programme. They are providing Trust-wide

	guidance with regard to IPC and PPE and advising on changes in guidance as they occur. **4 Cannula Value based procurement completed** The cannula value based procurement is on hold due to COVID-19. This is expected to be reinstated after the end of June, using two or three wards falling under one CBU per month in order to reduce the amount of multiple ward visits.

4. Recommendation

The Board is asked to receive this report for information.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 JULY 2020**
Agenda Item	**TB117/20a**	**FOI Exempt**	**NO**
Report Title	**CQC IMPROVEMENT PLAN UPDATE**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

This report provides an update on the progress of the CQC Improvement Plan, governance arrangements and assurance processes to ensure a continuous cycle of sustainable improvement.

Executive Summary

There were 31 identified 'must do' actions relating to breaches of regulation and 92 actions the CQC recommend we 'should do' as considerations to further support compliance. For this reporting period there has been accelerated progress in a number of areas. These are :

- Infection Prevention Control (including appropriate us of PPE equipment)
- Prescribing and administration of oxygen
- Paediatric Consultant cover and storage of patient records
- Resuscitation Trolley Checks Compliance
- Complaints responses

All other must dos are on track with the exception of 3 which are behind original timeframes set due to not meeting assurance threshold. These are :

- Mandatory Training (Executive leading programme of work)
- DNACPR and MCA (Audit currently being completed to assess position)
- Policy processes (delay in policy ratification during this time. Trajectory in place to recover)

Action has been taken to mitigate and recover time frames and will be reported to the Quality and Safety Committee.

Additional monitoring and real-time auditing of ongoing compliance ("Perfect Ward") is now being implemented which will provide ongoing assurance and will be reported through Trust governance arrangements

In line with the new cycle of business, the full action plan including the 'should dos' will be reported on a quarterly basis.

Recommendations

The Board is asked to note key actions and progress against the CQC Improvement Plan.

Previously Considered By:

✓ **Quality & Safety Committee**

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Jo Simpson	Jo Simpson

CQC Update June 2020

1. PURPOSE OF REPORT

The purpose of this report is to inform the Board about the progress of the CQC Improvement Plan following the publication of the CQC Inspection Report on 29 November 2019 and was rated as Required Improvement (RI).This report also outlines the assurance processes going forward to ensure a continuous cycle of sustainable improvement.

2. EXECUTIVE SUMMARY

There were 31 identified 'must do' actions relating to beaches of regulation and 92 actions the CQC recommend we 'should do' as considerations to further support compliance. **Appendix A** includes the latest Must Do action plan and detail to date. Due to the current Coronavirus pandemic, there has been limited progress in relation to improvements across some of the 'must dos', however we have also seen some significant improvement and progress in areas such as:

- Infection Prevention Control (including appropriate us of PPE equipment).
- Prescribing and administration of oxygen.
- Paediatric Consultant cover.
- Storage of patient records.
- Resuscitation Trolley Checks Compliance

A review of all actions, evidence and timescales is currently being undertaken and is expected to be completed by the end of June 2020. In line with the new cycle of business, the full action plan including the 'should dos' will be reported on a quarterly basis. Additional resources have been identified to support this review and compliance against the improvement plan and to support clinical staff to demonstrate improvement. As part of this review each of the actions have now been mapped against the Risk Register, risk status will be included in future reports. The overarching CQC risk – (2218) 'Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC has been downgraded from an extreme to high level risk' at the May 2020 Risk and Compliance Group.

Quality Assurance Panels (QAP) are due to be reconvened in June 2020 to review and test compliance and evidence to ensure improvements are embedded and sustained, the Medicines Management QAP will take place on 16th June.

3. PERFECT WARD

The Procurement process is now complete for the Perfect Ward audit 'App', Perfect Ward will support continuous improvement cycle, the Trust had secured funding to purchase a smart inspection App (Prefect Ward) which will help the Trust get the most of quality and clinical area audits. It will provide automated, real time reporting, everyone can immediately see where they are doing well and what needs to improve.

Perfect Ward will support the progress of actions within the CQC improvement plan and provide real time evidence of improvement, the roll out of Perfect Ward will be led by the Quality Team. Perfect Ward went 'live' on 1 May 2020, two audits are being rolled out across

both sites – The Matrons Checklist and Adult and Paediatric Harm Prevention, covering compliance against the following areas, this will also support improvement and delivery of the MIAA Quality Spot Checks Action Plan.

- Medicines Management
- Nutrition & Hydration
- Early Warning Scores
- Documentation
- Environment
- Patient Care (Pressure ulcers, EOL, MCA / DOLS)

There will be a total of 9 audits on the app:

- Matrons checklist
- Harm prevention
- SONAAS (Southport and Ormskirk Nursing Assessment and Accreditation Scheme)
- Ward / department safety
- Fundamentals of care
- Pharmacy (missed doses, medicine reconciliation)
- IPC (contents to be confirmed)
- Safeguarding
- Fluid balance (the subject of this audit will change allowing us to complete deep dives in to areas of concern)

A rollout plan has been developed; a full audit schedule covering all sites will be delivered within 8-10 weeks,

4. PROGRESS TO DATE

Trust Must Do BRAG ratings (not yet reviewed by Quality Assurance Panel)

Rating	Feb 20	Mar 20	Apr 20	May 20	Jun 20
Delivered and Sustained	0	0	3	1	1
Action Completed	4	8	9	9	13
On Track to Deliver	25	23	19	21	17
No Progress / Not Progressing to Plan	2	0	0	0	0
Total	31	31	31	31	31

Since the last report, two of the Must Dos in relation to the resuscitation checklist have moved from AMBER to GREEN as compliance against the My Kit Check electronic checklists has improved as compliance in relation to missed checks is back to 100%. As of 11th June the Trust has an overall compliance of 97.9% (100% overview check compliance, 97.9% missing items and 100% expired items), all missing item were replaced within the day if compliance remains at this level, the two Must Dos will return to BLUE in July 2020.

A further two additional Must Dos have moved into GREEN (Action Completed), these include two medicines management actions in relation to Hospital Pharmacy Transformation Plan (HPTP) and ensure the correct processes are followed for the management of controlled drugs (both subject to review by Quality Assurance Panel).

Actions Completed

- 41 & 87 (2019) - **The Trust must ensure patient records are stored securely in all areas (Medicine and Trust wide) (GREEN)** – New record trollies and locks have arrived on site and are awaiting the attention of the estates team. Integrated Governance (IG) Team continue to complete monthly compliance audits (next audits due w/c 15th June), due to the wards not being full to capacity during the Coronavirus pandemic and ward and clinical areas seeing less 'footfall' overall compliance with the secure storage of records and documentation has improved. The IG Team continue to work with staff in the wards and clinical areas to promote the importance of IG compliance.

- 51 (2019) - **The trust must ensure that all staff use appropriate infection prevention and control measures, in line with trust policy, especially when providing care and treatment to patients with identified infections in side rooms (GREEN):** A positive consequence of the Coronavirus pandemic has been the increase in compliance of the use of staff PPE and using appropriate signage on side rooms, prior to Covid-19, there was a positive improvement trajectory regarding signage compliance, this will be maintained as we move into phase II.

- 03 (2019) **- The trust must ensure that resuscitation trolleys contain the right equipment, which is in date and checked thoroughly and regularly according to trust policy (GREEN).**
- 111 (2019) - **The Trust must ensure that emergency equipment is checked regularly, recorded accurately and replaced appropriately, in line with trust policy. (GREEN).** Electronic resuscitation checks are in place and My Kit Check (electronic real time checklist) have now been extended to Deteriorating Patient trolleys As of 11th June the Trust has an overall compliance of 97.9% (100% overview check compliance, 97.9% missing items and 100% expired items), all missing item were replaced within the day

- **98 (2019) - The trust must address the Hospital Pharmacy Transformation Plan (HPTP) in a timely way.**) The Trust has approved a Pharmacy business case to increase staffing. Recruitment is nearing completion and pilots are moving forward for ward based services including SSU and 14A. Falsification on Medicines Directive business case approved and IT project well under way with scanners likely to be installed in June and software in July. EPMA funding has been obtained from NHSX and a specification has been produced for tendering purposes. The Pharmacy is currently open until 4pm on Saturday and Sunday and will be out to consultation for this to be permanent and to provide a small clinical service at the weekend. This has been delayed by Covid-19. The stock holding continues to be affected by the site configuration and COVID-19 supply requirements. However, the site review for a new facility on the Southport site is under way. The Trust has achieved a biosimilar conversion of 95.39% in line with the Model Hospital requirements.

- **100(2019) The trust must ensure the correct processes are followed for the management of controlled drugs.** Review of discharge processes undertaken by Professor Liz Kay and found to be legal. This review has proceeded to a work stream with actions taken to not release controlled drug discharge prescriptions without a wet signature, an update to the controlled drug policy to facilitate a group of single sign controlled drugs to facilitate timely provision of medicines to patients while maintaining security. The switch over of the ese medicines is delayed due to COVID-19. The drug and Therapeutics Committee (DTC) has agreed that the work stream group for controlled drugs will convert to an oversight group meeting quarterly and reporting into the DTC.

On Track to Deliver

- 39 (2019) - **The Trust must ensure that patients' privacy and dignity is maintained at all times (Medicine) (AMBER).** Ten out of the medicine core service wards and clinical areas have had their SONNAS reviews. In person centred care (Care standard 11) related to privacy and dignity, all wards have scored silver or higher with the exception of one ward. There have not been any complaints in relation to privacy and dignity within the medicine core service. The Matrons responsible for the Medical Core Services wards are also completing the 15 Steps Challenge on each other's wards and sharing feedback and best practice. The Perfect Ward App will support the monitoring of 'maintaining patients' privacy and dignity' for all clinical areas when rolled out. The 'SO Proud Go See visits are also due to reconvene in June and July 2020.

- 78 (2019) - **The trust must ensure that all staff completes mandatory training requirements (Surgery) (GREEN).** Levels of mandatory training in planned care have exceeded target 85% at 88.9%, trajectories have been set for role specific mandatory training and compliance. There are still some gaps in paediatric resuscitation support training, time scales have been reviewed and Surgery are expected to achieve their paediatric resuscitation compliance by August 2020, as the Resuscitation Team have recommenced training in May 2020.

- 81(2019) - **The Trust must ensure that oxygen is prescribed and administered appropriately (GREEN).** During the Coronavirus pandemic, an Oxygen usage monitoring tool has been developed by BI and rolled out across all clinical areas on both sites. To enable this to function effectively it relies on the correct information about oxygen prescribing and administration to be input into Medway and Vital Pac. The monitoring tool is successfully being utilised across all areas. It is expected to be continued to be used post recovery, therefore moving this risk to Green.

  A clinical audit has demonstrated that there is an improvement in oxygen prescribing and that there has been a change from recording administration on the drug chart to recording the flow rate is on VitalPac which then provides the dashboard.

- 01 (2019) - **The Trust must ensure that every child is seen by a consultant paediatrician within 14 hours.(GREEN)**
  07 (2019) - **The Trust must ensure that there are enough medical staff to meet the needs of the service, particularly at consultant level. (GREEN)**
  The Core Service is still awaiting feedback on whether approval has been given to progress with a Statement of Case for additional consultant paediatricians. However, the decision to temporary close the Paediatric ED department between 22.00-08.00 during Coronavirus pandemic has provided temporary mitigation as attendances during these times are low, and current attendances have decreased to 40% of expected. A review of any children not seen within 14 hrs (prior to Coronavirus pandemic has been completed and has found no harms have occurred and no Serious Incidents (SIs) have been reported to date in 2020). Since the change in opening hours from 6 April 2020, no patients have waited longer than 14 hours to be seen by a consultant.

- 44 (2019) - **The trust must ensure local governance process address areas of poor practice. (AMBER)**
- 45 (2019) - **The trust must ensure it has effective systems to manage risk and performance. It must ensure actions are taken to mitigate against known risks and audits of service performance are consistent and provide relevant information to improve services. (AMBER)**

Trajectories have been agreed and are in place for overdue complaints and actions, as of 12 June 2020, there are zero complaints awaiting response over the 40 day standard. There are currently no overdue STEIS and a trajectory is in place for any overdue moderate harms with Urgent Care and Planned Care CBUs.

Not Progressing to Plan / Risks to Delivery

- 96 (2019) - **The Trust must ensure that staff are competent for their roles and that competency records are maintained for staff**. **(AMBER)** A Trust wide Clinical Competency Working Group was established Feb 2020. In response to the pandemic, an upskilling clinical skills training programme was designed and delivered by the Nurse & Medical Education Teams and work continued throughout to undertake a training needs analysis for the Top 10 risks for all staff. From this, the TNA for medicines safety was finalised & is now reported monthly via the role specific training report & at CBU PRBs. A review of all clinical skills induction and training courses is underway with statements of case being revised to a) establish an organisational clinical skills training team, b) improve facilities and c) secure funding via the HEE NHS Education Contract for resources, equipment & consumables to support this programme.

- 90 (2019) - **The trust must ensure that all policies are reviewed in a timely way. (AMBER)** There are still a number of policies awaiting ratification at the Policy Review Group (PRG), the Associate Director of Corporate Governance (ADCG) is reviewing ratification and assurance process to re-establish a trajectory.

- 42, 53, 75, 86 (2019) – **Four actions relating to consent, documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans (AMBER)** Working group has been established with nursing, medical, safeguarding, resuscitation team and hospice representation. Safeguarding training compliance hasn't seen any further improvement in Quarter 4 due to the Coronavirus pandemic. The Safeguarding Team continue to undertake their knowledge based audits and usual processes are still being adhered to. Due to potential increase in DNACPR orders being made, a non-patient facing clinical member of staff has completed an audit on DNACPRs, the results are being reviewed and the findings will inform the Terms of Reference for the working group.

Medicines Management

Across Medicines Management the compliance with the CQC must do actions is being maintained throughout the management of Coronavirus Pandemic. Weekly Work Stream meetings have recommenced for 'Safe and Secure Handling of Medicines'.

Data Intelligence: The Perfect Ward

The introduction of the Monthly Matron's Checklist on The Perfect Ward is providing the project team with smart, reliable information with which to inform compliance levels, progress and areas requiring improvement. The data is to be triangulated with the information collated by the Pharmacy Assistant Technical Officers to provide additional insight. (At present only 9 Wards are live on The Perfect Ward but this will be increasing to all 33 Clinical Areas over the next two months)

Compliance Audits – Expired Medicines, Temperature Checks, Ward Trolleys

Covid-19 Phase 1 pressures have had a negative impact on compliance levels. The Trust's Quality Matrons are now returning to the wards to support the teams with their improvement

plans to reverse this trend. Additional Pharmacy Assistant Technical Officers are also being trained to increase the number of staff undertaking checks.

- 100% of Medications in date in Ward Cupboards (9 wards)
- 100% of Medications in date on Resus & Deteriorating Patient Trolleys (8 wards)
- 100% All IV fluids in date on ward (9 wards)
- 67% of Medicines in Drugs Trolleys are up to date (9 wards)
- 56% of wards were compliant with Daily Clinical Room and Fridge Temperature checks (over previous 30 days.) (9 wards.)

Deep dive into Perfect Ward data triangulated with Pharmacy ward audits will confirm which areas require additional support. Work with Pharmacy Assistant Technical Officers is planned to understand whether issues are promptly escalated and correct actions taken (for example if a fridge is out of range is it escalated and reported on Datix.)

Ward Pharmacy Assistant Technical Officers

The Pharmacy Team is in the fourth week of a PDSA for a revised and extended role for a Band 4 Pharmacy Ward Technician on Ward 9A (Short Stay Unit.) A SOP based on the success of the Band 5 role on Ward 14A is informing the trial which it is hoped will be extended shortly onto FESS. The extended role includes the entry of medicines into the E-Discharge system to support timely and accurate ordering of inpatient and discharge medicines system and management of bedside lockers.

The new role of the Band 5 Technicians is being developed to include patient counselling and reconciliation of medicines at discharge. There is discussion as to whether temperature and expiry date checks can be added into the role of the Band 4 Technician.

5. RECOMMENDATIONS & NEXT STEPS

The Board are asked to note:

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

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	New Theme	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Proposed RAG	Lead
01 (2019)	Children & Young People	Regulation 12(2)(a)	Must Do	Safe	7 Day Services	The trust must ensure that every child is seen by a consultant paediatrician within 14 hours	●Review supporting workforce to understand options regarding service delivery, report findings to inform business planning cycle ●Monthly audit of clinical records to assure children not seen in timeframe are not compromised ●Review number of incidents	●Statement of case completed including QIA ●Annual business cycle ●Monthly Audit completed and presented at CBU Governance forums ●Reduction in number of incidents	● ~~Feb 2020~~ *Temporary completion and mitigation in April 2020 following changes to opening hours of children's ED*			MD
03 (2019)	Children & Young People	Regulations 12(1)(2)(e); 17(2)(b)	Must Do	Safe	Resus	The trust must ensure that resuscitation trolleys contain the right equipment, which is in date and checked thoroughly and regularly according to trust policy	● Electronic resus trolley checks in place and can be accessed at any time and audited monthly, results discussed at daily huddle	● Compliance reports and alerts from electronic checklist ● Monthly audits	●Jan-20 - **completed review in June 20**			DON
11 (2019)	Children & Young People	Regulation 18(2)(a)	Must Do	Safe	Mandatory Training	The trust must ensure that all staff members attend mandatory training, and that compliance for resuscitation training is improved, particularly for medical staff.	● Ascertain compliance for both medical and nursing staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training (to be completed by the resuscitation team). ● Additional training dates to be made available for Jan / Feb-20.	●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of resuscitation training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance. ● Discussed through appraisal meetings	●July-20			HROD
16 (2019)	Children & Young People	Regulation 18(1)	Must Do	Safe	Staffing	The trust must ensure that there are enough medical staff to meet the needs of the service, particularly at consultant level.	●Recruit into Consultant Paediatrician for Community ● Review supporting workforce to understand options regarding service delivery, report findings to inform business planning cycle ● Monthly audit of clinical records to assure children not seen in timeframe are not compromised ● Review number of incidents	● Undertaken review of SLA ● Recruitment for Consultant Paediatrician for Community underway - discuss in April panel ● Statement of case completed including QIA ● Annual business cycle	● ~~Feb 2020~~ *Temporary completion and mitigation in April 2020 following changes to opening hours of children's ED*			MD
39 (2019)	Medicine	Regulation 10 (2)(a)	Must Do	Caring	Privacy & Dignity	The trust must ensure that patients' privacy and dignity is maintained at all times.	● Immediate Action taken at the time as outlined in Letter Dated 3rd September 2019 Ongoing Assurance measures ● Rollout SONAAS accreditation Scheme across all adult inpatient areas ● SONAAS action plans to be implemented and monitored. ● Peer review of Patient experience at the organisation to evaluate level of corroboration of intelligence to demonstrate continual improvement ●Related ongoing National and Local survey results to be actioned. ●#endpjparalysis education to patients and families to provide patients own clothes.	Over-all Measure of Success Intelligence will be corroborated and reported from a number of sources (e.g. below) to evaluate Privacy and Dignity as part of Patient Experience Strategy for the Trust ● complaints and themes ● PLACE Audit ● Inpatient Survey Results ● Friends and Family Test ● Complaints/Concerns ● Matron Checklist ● SONAAS Care Standard 11 ● Healthwatch Survey reports ● Go See visits by Quality Team, findings to be reported directly to Ward Managers and Heads of Nursing	● SONAAS Accreditation Rollout by Mar-20 - **phase 1 Completed** ● NHS Leadership Patient Experience Lead 1 day a week commencing Jan-20 - **Completed** ● Evaluation of Patient Experience at the Trust Feb-20 **Completed** ● Go see visits to be agreed and dates diarised from ~~April 20~~ *Revised dates June 20* in preparation for the Mock CQC programme for Medicine core service commencing ~~May 20~~ *Revised dates June 20 where this must do will be evaluated*			DON
41 (2019)	Medicine	Regulation 17 (2)(C.)	Must Do	Safe	Documentation	The trust must ensure patient records are stored securely in all areas.	● Complete audit of Record trolleys in all clinical areas ● Action any findings through procurement to replace any records trolleys that are not fit for purpose ● Ongoing Audit programme to provide assurance ● SOP to be created in conjunction with medical records, ward staff and matrons concerning the correct use and storage of patient information.	● Audit completion of records trolleys ● Develop business case for any replacement trolleys ● Audit of Compliance reported to information Governance	● Dec 19 **audit completed** ● Feb 20**funding sourced** ● Order Feb 20 **complete now in stock** ● Audits reported bi-monthly to Information Governance Steering Group - last meeting Feb **next due June -20**			DF
42 (2019)	Medicine	Regulation 17 (2)(C.)	Must Do	Effective	Safeguarding / Mandatory Training	The trust must ensure care and treatment of patients is provided with their consent. They must ensure when patients lack capacity to consent staff complete a capacity assessment in line with legislation, especially when using do not attempt resuscitation orders.	●Safeguarding training to be delivered to all AHP/Nurses/doctors regarding capacity. ●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ● If compliance not achieved the CBU provides assurance of improving compliance and a trajectory to the Safeguarding Assurance Board ●Safeguarding team to ensure that mental capacity training is included in other relevant training programmes ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics ● Review audit cycle	●Achievement and sustaining the 90% compliance for MCA training ● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees ● Content of Safeguarding training includes mental capacity ● Quartile audit of the number of completed 2 stage capacity assessments prior to deprivation of liberty application ●Delivery of awareness sessions regarding DNACPR and capacity to be undertaken for medics	●~~Apr 20~~ for training actions. *Revised date June 20* ●Jun- 20			DON / MD

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	New Theme	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Proposed RAG	Lead
44 (2019)	Medicine	Regulation 17 (2)(a)	Must Do	Well Led	Governance	The trust must ensure local governance process address areas of poor practice.	● Complaints to be completed within the 40 day timescale ● RCA's will be completed within the 60 day timescale ● Learning from complaints and RCA's will be shared with areas ● Audits to measure changes in practice will be implemented ● RCA's to be completed within 60 day deadline ● Review of governance structure and accountability within CBU	● Complaint Timescales reporting ● Evidence of Audit reporting and actions within CBU Governance Arrangements ● RCA's with timescales reporting delivered within 60 day timescale ● Governance restructure options in place underpinned by an accountability framework	● Complaint 40 day timescale June-20 ● RCAs compliant by June-20 ●Learning from complaints(to follow straight after complaint response) June-20 ● Develop audit programme for learning from complaints June-20 ● Governance Structure and accountability framework June-20 ● Significant reduction in timescales. Must do to be rested at Panel July 20 to confirm RAG rating		A	DON
45 (2019)	Medicine	Regulation 17 (2)(a)(b)	Must Do	Well Led	Governance	The trust must ensure it has effective systems to manage risk and performance. It must ensure actions are taken to mitigate against known risks and audits of service performance are consistent and provide relevant information to improve services.	● Put additional support in place to streamline processes to ensure there are effective governance systems in place relating to :- * risk registers (mitigation of risks, gaps in controls) * weekly patient safety meetings to discuss Incidents, complaints * Review of daily, weekly and monthly ward checklists * Improve the performance management system in relation to the ward checklists *Improve attendance at Mortality and Morbidity meetings ● Appraise the market for real-time audit and performance checklists to improve consistency and deliverer of improvements ● Re-assessment of core service of Medicine using KLOE methodology	● Additional Resource will be in place ● Metrics related to risk and performance will reach the required standard included in Must do related to complaints. In addition :- * risk registers (mitigation of risks, gaps in controls) * weekly patient safety meetings to discuss Incidents, complaints * Review of daily, weekly and monthly ward checklists * Improve the performance management system in relation to the ward checklists *Improve attendance at Mortality and Morbidity meetings ● An effective system will be in place to monitor performance which is reported upon through effective governance arrangements ward to board ● Mock CQC inspection will be completed and there will be improvement in well-led domain evidenced with improvements outlined	● Additional Support Feb-20 - **Complete** ● Metrics Mar-20 - **Complete** ● Effective Systems Mar-20 **Complete** ~~● Mock CQC programme for Medicine core service commencing Apr-20 -~~ ● Go see visits to be agreed and dates diarised from April-20 Revised dates June 20 in preparation for the Mock CQC programme for Medicine core service commencing May-20 Revised dates July 20 due to change in Leadership team in medicine.			DON
49 (2019)	Medicine	Regulation 12 (2)(b)	Must Do	Safe	Health & Safety	The trust must ensure that substances that are hazardous to health are locked away safely. It must ensure it acts on patient safety alerts to securely store superabsorbent polymer gel granules.	● COSHH cupboards ordered and fitted in all wards and clinical areas ● COSHH files including alerts to be held in wards and clinical areas ● Re-circulation of PSA 2017 003 related to ingestion of Polymar gel granules ● COSHH assessors in place for each ward ● Provide bespoke training for COSHH assessors ● Audit programme of COSHH Inspections by designated H&S Officer ● Complete risk assessment for all wards and clinical areas ● Produce a Trust Wide COSHH database with Manufacturers Safety Data Sheets (SDS) and completed COSHH assessments for all areas ● Provide risk COSHH assessment training to all staff undertaking environmental risk assessment	● COSHH cupboard in place ● Files availability assessed a part of H&S monthly audit ● Circulation evidenced via communication tools used ● Assessors named for each ward/department ● Audit results presented as part of audit cycle ● Completed Risk assessments evaluated by designated trust H&S lead ● Database in place with both SDS and risk assessments ● Produce training package and schedule of dates to undertake the training Produce training package and schedule of dates to undertake the training	● Nov 2019 - **complete** ● Feb 20 - **complete** ● Dec 19 - **complete** ● Jan 20 - **complete** ● Jan 20 - **complete** ● Feb 20 - **complete** ● Feb 20 - **complete** ● Mar 20 - **complete**			DCEO
51 (2019)	Medicine	Regulation 12 (2)(h)	Must Do	Safe	IPC	The trust must ensure that all staff use appropriate infection prevention and control measures, in line with trust policy, especially when providing care and treatment to patients with identified infections in side rooms.	● Immediate actions taken (see letter dated 3rd September 2019) ●Signage to be bought for Southport Site ●Three monthly audits in place - reported as part of the IPC monthly report ● Audit reporting to be embedded into IPC governance process ● Signage to be bought for Ormskirk Site	●Signage in place ●Audits in place and being reported monthly ●IPC and audit programme ●Signage in place	● Sep 19 - **complete** ● Jul 19 - **complete** ● Dec 19 - **complete** ● Feb 20 - **complete** ● Feb 20 - **complete**			MD
53 (2019)	Medicine	Regulation 13 (6)(d)(7)(b)	Must Do	Effective	Safeguarding or Mandatory Training	The trust must ensure staff complete a capacity assessment before depriving patients of their liberty and ensure they do not restrict patient's liberty of movement without legal authority.	● Safeguarding training to be delivered to all eligible AHP/Nurses/doctors regarding capacity and DoLs ● All relevant staff, as per the trusts TNA, to complete the blended learning mental capacity training ● Each CBU to monitor their training compliance ● When compliance not achieved the CBU provides assurance of improving compliance and a trajectory at the Safeguarding Assurance Board ● Safeguarding team to ensure that mental capacity training is included in other relevant training programmes ● Review audit cycle	● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees ● Content of Safeguarding training includes mental capacity ● Quartile audit of the number of completed 2 stage capacity assessments prior to deprivation of liberty application	● Feb 20 - **completed** ~~●Apr-20 for training actions.~~ **Revised date July 20** ●Jun- 20 ● June 20			DON

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	New Theme	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Proposed RAG	Lead
62 (2019)	Medicine	Regulation 18 (2)(C.)	Must Do	Safe	Staffing	The trust must deploy sufficient nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.	● Daily staffing to be reviewed by HoN and matrons to ensure staffing is safe ● Weekend staffing review to be undertaken on Friday matron cover over the weekend to support safe staffing ● Corporate nursing to complete 6 monthly staffing review of areas to ensure patient dependency matches the establishment ● Staff to compete datix where short falls in staffing are happening ● Develop a long term nursing workforce plan (including overseas and Home Grown initiatives)	● Staffing templates to be completed weekend matron rota ● Safer Nursing Care Tool review six months ● Utilise Datix red flags regarding staffing ● Utilise Datix red flags regarding staffing	● Aug-19 - **completed** ● ~~May-20~~ **Revised date June 20** ● Nov 19 **- completed** ● **June update. Risk rating reduced from extreme to high but awaiting ratification at Risk and compliance. Impact of COVID on staffing reporting has impacted on not completing this must do. re progrees 3 year workforce plan near completion. international recuitment commenced. Planned Student nurse numbers increased by 50% 2020/21. Minimum of 10 nurse Apprenticeships planned Sept 20**			DON
72 (2019)	Surgery	Regulation 12	Must Do	Effective	Equipment Checks	The trust must ensure that all safety checks are completed in theatre in line with national guidance.	●Continue to review WHO audit compliance ●Identify areas for improvement, share good practice ● Relevant action from the audits to be embedded in practice.	●Increase WHO audit compliance to 100% ● Spot checks to be conducted by Matron	● Mar 20 **- completed**			DON
75 (2019)	Surgery	Regulation 17(2)(C.)	Must Do	Effective	Safeguarding	The trust must ensure that all staff can complete documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately.	●Safeguarding training to be delivered to all AHP/Nurses/doctors regarding capacity. ●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ● If compliance not achieved the CBU provides assurance of improving compliance and a trajectory to the Safeguarding Assurance Board ●Safeguarding team to ensure that mental capacity training is included in other relevant training programmes ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics ● Review audit cycle	● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees ● Content of Safeguarding training includes mental capacity ● Quartile audit of the number of completed 2 stage capacity assessments prior to deprivation of liberty application	●~~Apr-20 for training actions.~~ **Revised date June 20** ●~~May-20~~ **Revised date June 20** ●Jun- 20			DON
78 (2019)	Surgery	Regulation 12(2)(C.)	Must Do	Safe	Mandatory Training	The trust must ensure that all staff completes mandatory training requirements.	● Ascertain compliance for all staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training.	●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of Mandatory Training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●~~Apr-20~~ **–Completed, but will need to maintain - check again July 20**			HROD
79 (2019)	Surgery	Regulation 12(2)(C.)	Must Do	Safe	Mandatory Training	The trust must ensure that theatre staff, supporting the urgent and emergency department are trained to support paediatric patients.	● TNA to be completed ●Training dates to be circulated and all staff to be booked on the training based on their individual TNA. ●Trajectory for staff to be trained in Paediatric Life Support.	●Training Compliance targets achieved ● Reports showing compliance against paediatric levels of resuscitation training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●~~Apr-20~~ **- Revised date July 20**			DON
81 (2019)	Surgery	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must ensure that oxygen is prescribed and administered appropriately.	● Oxygen Audit to be completed and action plan to be developed and reported to Clinical Audit Group and incorporated into Medicines Management Quality Improvement Plan	● All Oxygen unless given in an emergency is prescribed on the prescription charts. ● All Oxygen is administered correctly as assessed by??	●Mar-20 - **Audit completed** ●Jun / July -20 -Re Audit / improvement			MD
86 (2019)	Trust Wide	Regulation 17(2)(C.)	Must Do	Effective	Documentation	The trust must improve its record keeping in relation to 'Do Not Attempt Cardio-pulmonary Resuscitation' orders and capacity assessments.	●Review TNA ensure all identified staff complete the blended learning mental capacity training (MCA) ●CBUs to monitor their (MCA) training compliance at Governance meetings ●Awareness sessions regarding DNACPR and capacity to be undertaken for medics	●Achievement and sustaining the 90% compliance for MCA training ● Trajectory for training with action plan in place ● Each CBU achieve and sustain 90% compliance ● Safeguarding training compliance part of Performance Review Panel Board Pack ● Attendance of CBU representation at Safeguarding Committees ● Content of Safeguarding training includes mental capacity ● Quartile audit of the number of completed 2 stage capacity	●~~Apr-20 for training actions.~~ *Revised date June 20* ●Feb- 20 - *Completed* ● *June audit ongoing. MD to lead*			MD
87 (2019)	Trust Wide	Regulation 17(2)(d)	Must Do	Safe	Documentation	The trust must ensure that records are securely stored.	● Audit completion of records trolleys ● Develop business case for any replacement parts eg locks so that kit is fit for purpose ● Audit of Compliance reported to information Governance	● Completed Audit ● Completion of business case for replacement parts eg locks so that kit is fit for purpose ●Improved compliance with bi-monthly trolley audits	● Dec 19 **audit completed** ● Feb 20 **funding sourced** ● Order Feb 20 **complete now in stock** ● Audits reported bi-monthly to Information Governance Steering Group - **last meeting Feb next due May -20**			DF

Ref No	Core Service	Regulation No	Must Do / Should Do	Domain	New Theme	Area for improvement	Actions to be delivered	Measure / Evidence	Timescales	RAG	Proposed RAG	Lead
90 (2019)	Trust Wide	Regulation 17(2)(a)	Must Do	Effective	Governance	The trust must ensure that all policies are reviewed in a timely way.	● A change of process is underway which will include transferring policy management to the Associate Director of Corporate Governance (ADCG) ● Undertake a review of the: a. Policy ratification process b. PRG composition and ToRs c. Overall management of policies ● Develop new reporting process by the Assistant to the ADCG who start with the Trust in mid Jan 20.	● Robust monitoring assurance process in relation to policies ● No out of date policies	● Apr-20 - ***Revised date July 20 (TBC)***			COSEC
96 (2019)	Trust Wide	Regulations 17(2)(d);18(2)(a)	Must Do	Safe	Staffing	The trust must ensure that staff are competent for their roles and that competency records are maintained for staff.	● Developed a robust system and process to monitor and report staff competencies ● Establish mandatory training task and finish group ● Ascertain compliance for all staff in individual areas - targeting levels of low compliance immediately ● Set trajectories with key leads to improve compliance ●TNAs to be reviewed to ensure staff are aligned to the correct level of training.	● Effective monitoring process in place for staff competencies ●Mandatory Training Compliance targets achieved ● Reports showing compliance against all levels of Mandatory Training to be circulated to all ward / dept. managers to ensure staff awareness and bookings completed to achieve compliance.	●Jun-20			HROD
110 (2019)	Urgent & Emergency Care	Regulation 12 (2)(b)	Must Do	Safe	Health & Safety	The trust must ensure that the risks to the health and safety of service users are assessed and that all is done to mitigate any such risks.	● Audit of patient risk assessment documentation ● Staff training and awareness sessions regarding completing risk assessments	● Completion of monthly audits ● Spotchecks by Matron ● Staff awareness sessions / training at daily huddles ● Review of current documentation	● Jan 20 (monthly) Completed ● Mar 20 **Completed** ● Apr 20 **Completed**			DON
111 (2019)	Urgent & Emergency Care	Regulation 12 (2)	Must Do	Safe	Equipment Checks	The trust must ensure that emergency equipment is checked regularly, recorded accurately and replaced appropriately, in line with trust policy.	● Electronic resus trolley checks in place and can be accessed at any time and audited monthly ● Results discussed at daily huddle ● New lockable equipment trolleys at bedside in resus bays, each has a daily checklist which will be made electronic going forward	● Compliance reports and alerts from electronic checklist ● Monthly audits	●Jan-20 - **completed review in June 20**			DON
56 (2019	Medicine	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must ensure the proper and safe management of medicines. The trust must ensure all medications are within their expiry dates. They must ensure controlled drugs are prescribed and supplied to patients in adherence with the legal requirements.	**Delivery of the Medicines Management Quality Priority which include** ● **Safe and Secure Medicines:** To ensure the safe and secured management of medicines in order to deliver patient requirements and meet legislation. ●**Controlled Drugs**: To ensure the safe and secure Management of Controlled Drugs in order to deliver patient requirements and meet legislation. ●**Workforce**: To develop a structured and empowered team with clear roles and responsibilities who deliver patient and legislative requirements seven days a week. ●**Governance & Leadership:** To develop a robust governance and leadership framework to ensure the effective and efficient delivery of medicines management. ●**Governance & Leadership:** To develop a robust governance and leadership framework to ensure the effective and efficient delivery of medicines management. ●**CQC Assurance**: To provide the required assurance through reporting that all CQC recommendations are being acted upon and to ensure that they are delivered as a priority as part of the programme schedule. (CQC Must Do and Should Do requirements fall across the 8 Project areas of the Programme.) ●**Electronic Prescribing and Medicines Administration System (EPMA):** To modernise the Pharmacy Service through information technology to improve medicines management and patient care. ●**Automated Ward Drugs Storage Systems** To modernise medicines optimisation at ward level reducing risk of medicines administration errors, reduce missed doses of medicines and increase accountability of stock. ●**Automated Pharmacy System to support the delivery of the Falsification of Medicines Directive** To replace and maintain the standards of dispensing practice by replacing old technology with more advanced solutions that also provide compliance with FMD. ●**Centralised Temperature Monitoring System** To modernise clinical area storage and provide assurance that medicines in clinical areas are stored correctly to provide optimised care for our patients.	●Various KPIs and outcome measures are included as part of the Medicines Management Priority ● Develop sustainability plan to over see embedding of improvements	● Immediate Action Plan Complete - Jul-19 ● 30 Day Action Plan Complete - Aug-19 ● 3 month Action Plan -completed Oct-19 ● 9 month Action Plan - April-20 - TBC ● Develop sustainability Plan - Sept 20			MD
80 (2019)	Surgery	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must ensure that medicines, including controlled drugs, are stored, prescribed, administered, recorded and disposed of according to national guidance.						MD
82 (2019)	Surgery	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must ensure staff respond appropriately to fridge and environmental temperatures outside of accepted safe ranges.						MD
98 (2019)	Trust Wide	Regulation 12 (2)(g)	Must Do	Well Led	Medicines Management	The trust must address the Hospital Pharmacy Transformation Plan (HPTP) in a timely way.						MD
99 (2019)	Trust Wide	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must become compliant with the Falsification of Medicines Directive (FMD)						MD
100 (2019)	Trust Wide	Regulation 12 (2)(g)	Must Do	Safe	Medicines Management	The trust must ensure the correct processes are followed for the management of controlled drugs.						MD
101 (2019)	Trust Wide	Regulation 12 (2)(g)	Must Do	Well Led	Medicines Management	The trust must produce a clearer vision for medicines optimisation across the trust and resolve immediate medicines optimisation issues identified during our inspection.						MD

‘Covid 19’ presentation

Patient data

Oxygen therapy

ED Activity

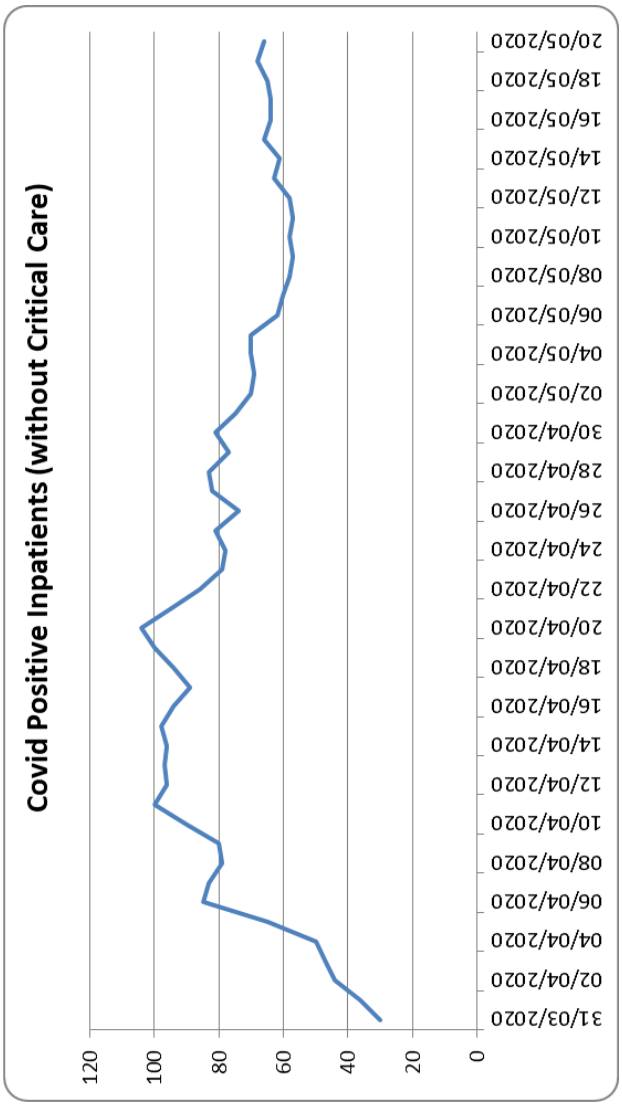
Sickness rates by Occupation

Healthcare Acquired infection

Mortality Rates and reviews

Trust Board July

NHS
Southport and Ormskirk Hospital
NHS Trust


Covid Positive Inpatients (without Critical Care)
120
100
80
60
40
20
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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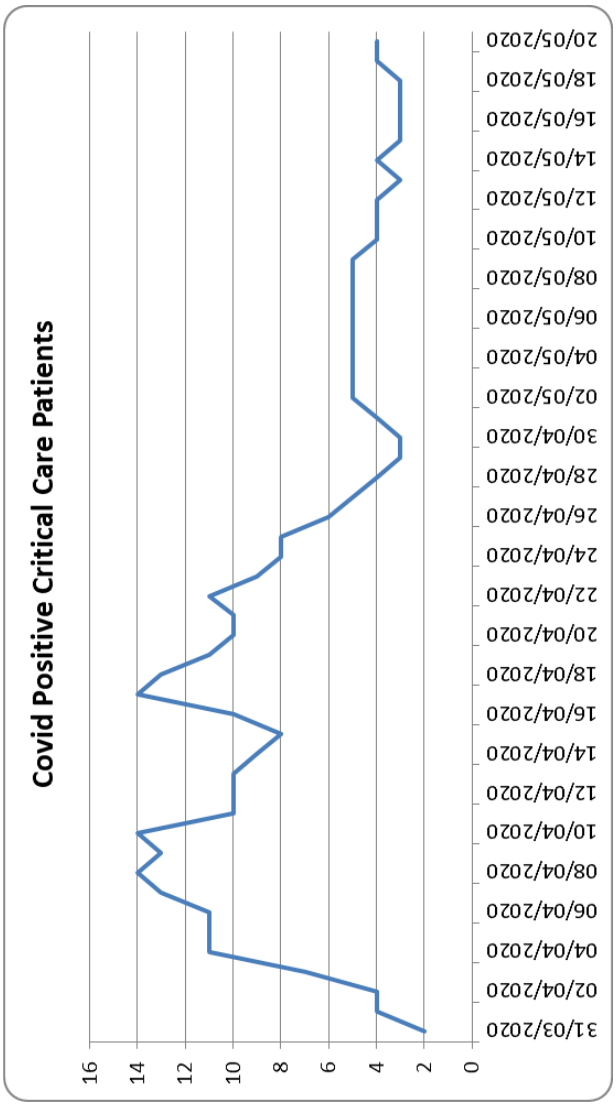
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Covid Positive Critical Care Patients
16
14
12
10
8
6
4
2
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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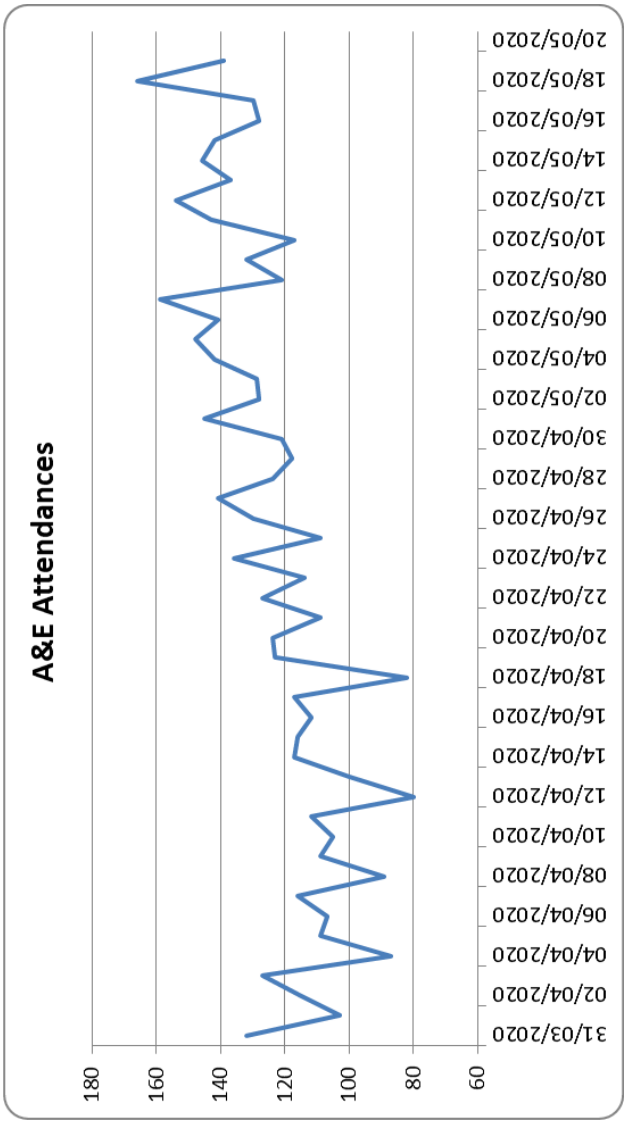
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


A&E Attendances
180
160
140
120
100
80
60
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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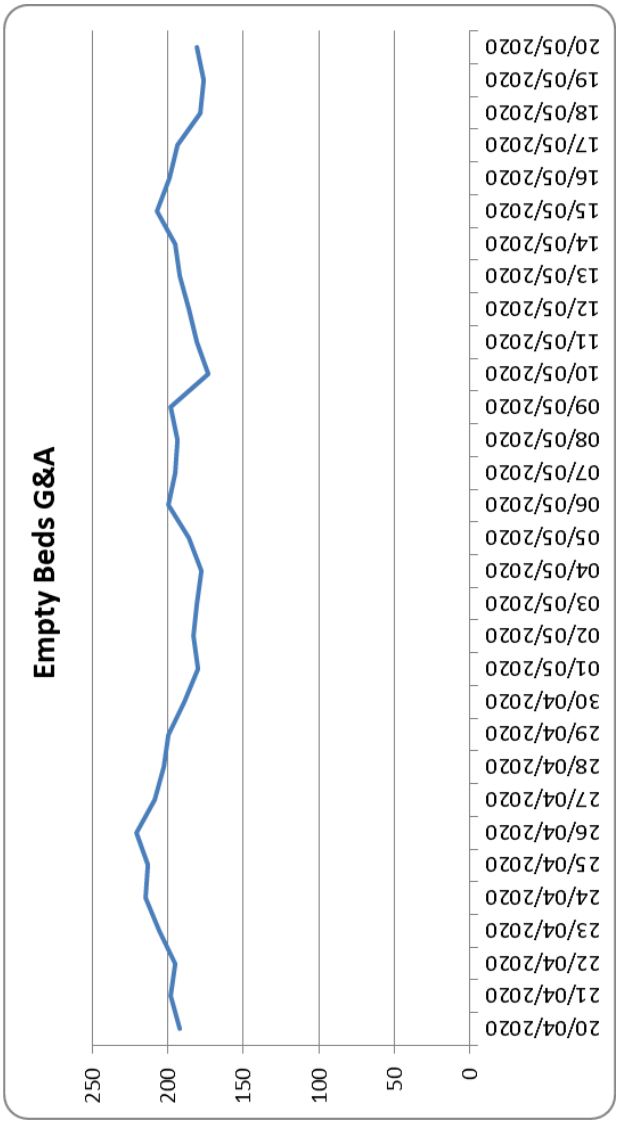
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Empty Beds G&A
250
200
150
100
50
0
20/04/2020
21/04/2020
22/04/2020
23/04/2020
24/04/2020
25/04/2020
26/04/2020
27/04/2020
28/04/2020
29/04/2020
30/04/2020
01/05/2020
02/05/2020
03/05/2020
04/05/2020
05/05/2020
06/05/2020
07/05/2020
08/05/2020
09/05/2020
10/05/2020
11/05/2020
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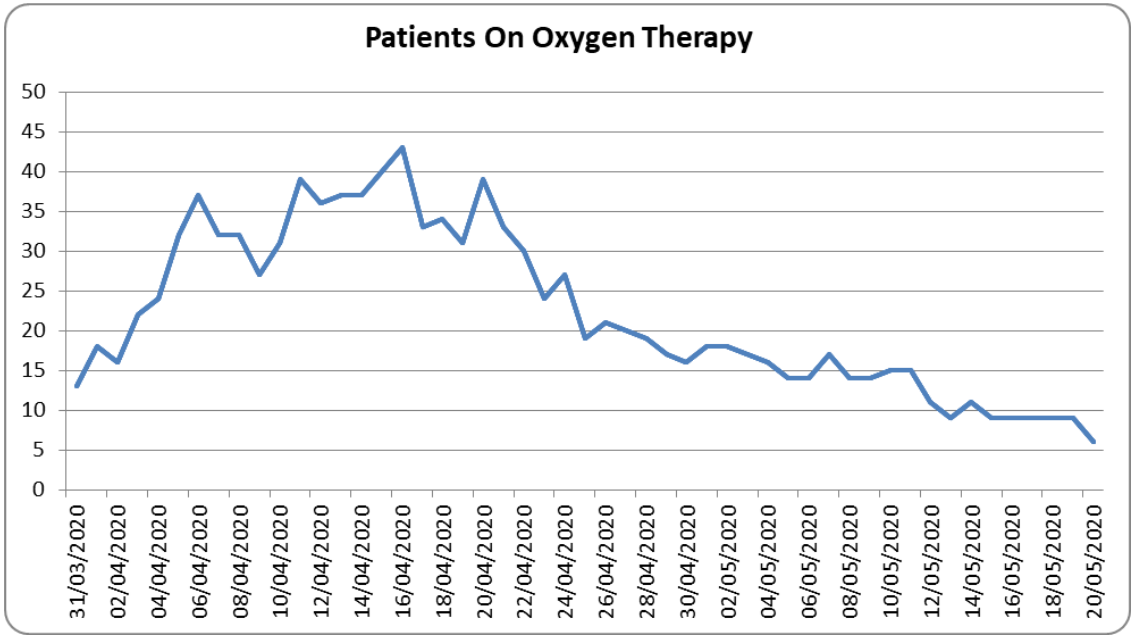
15/05/2020
16/05/2020
17/05/2020
18/05/2020
19/05/2020
20/05/2020


Patients On Oxygen Therapy
50
45
40
35
30
25
20
15
10
5
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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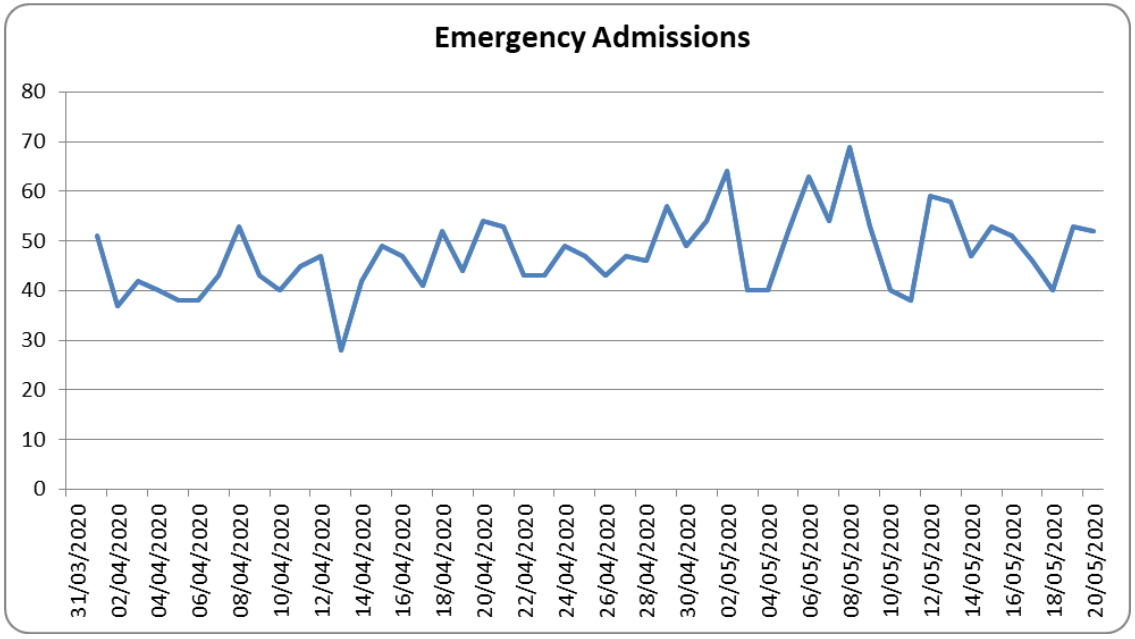
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Emergency Admissions
80
70
60
50
40
30
20
10
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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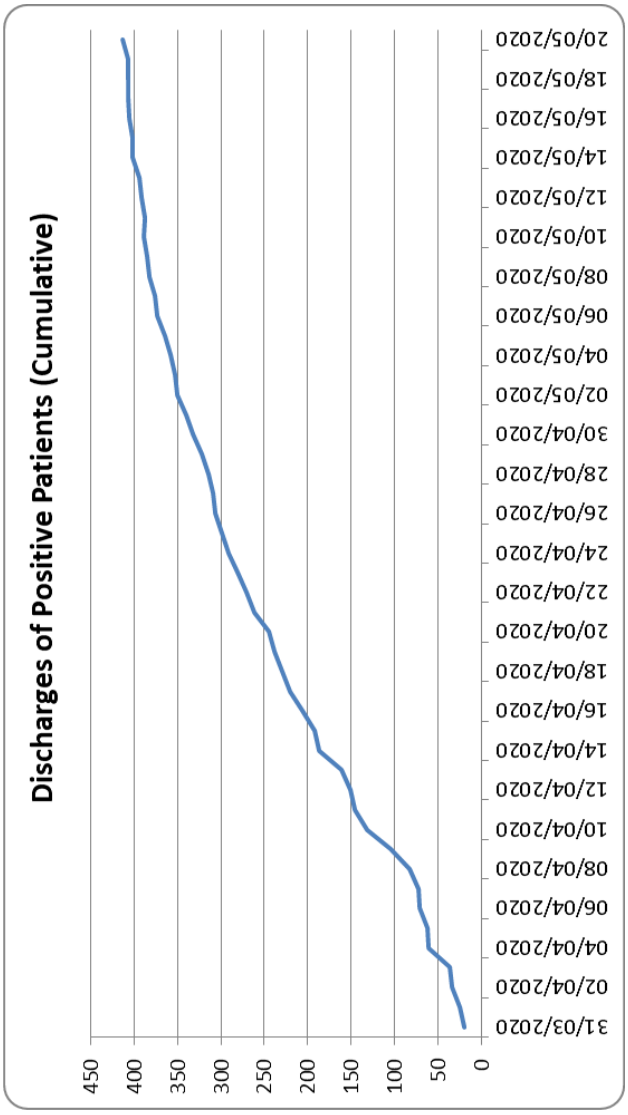
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Discharges of Positive Patients (Cumulative)
450
400
350
300
250
200
150
100
50
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
04/05/2020
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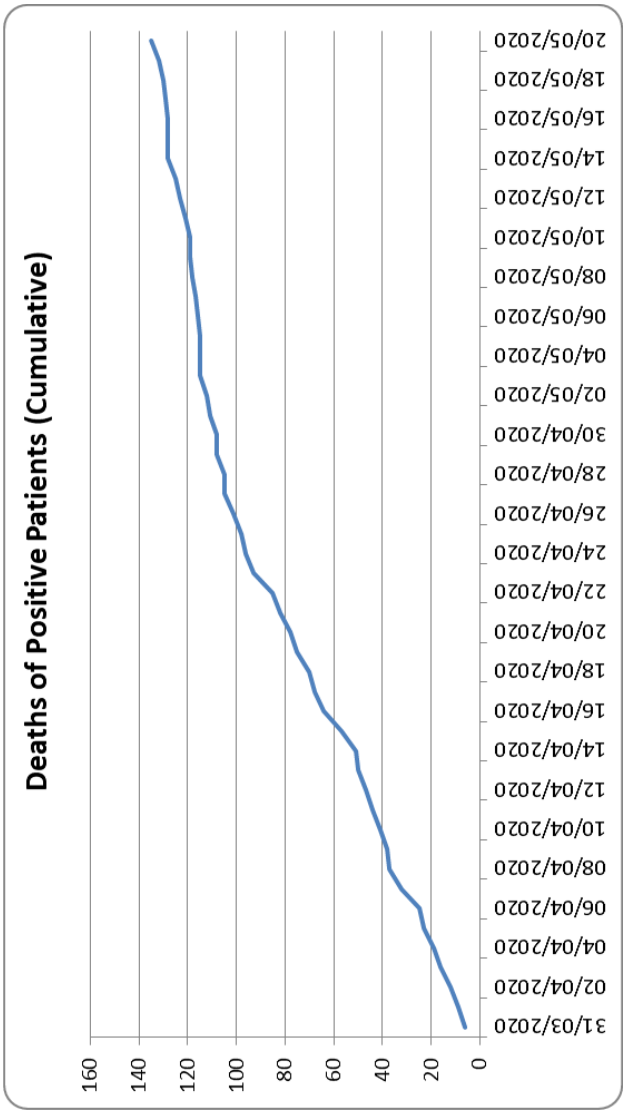
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Deaths of Positive Patients (Cumulative)
160
140
120
100
80
60
40
20
0
31/03/2020
02/04/2020
04/04/2020
06/04/2020
08/04/2020
10/04/2020
12/04/2020
14/04/2020
16/04/2020
18/04/2020
20/04/2020
22/04/2020
24/04/2020
26/04/2020
28/04/2020
30/04/2020
02/05/2020
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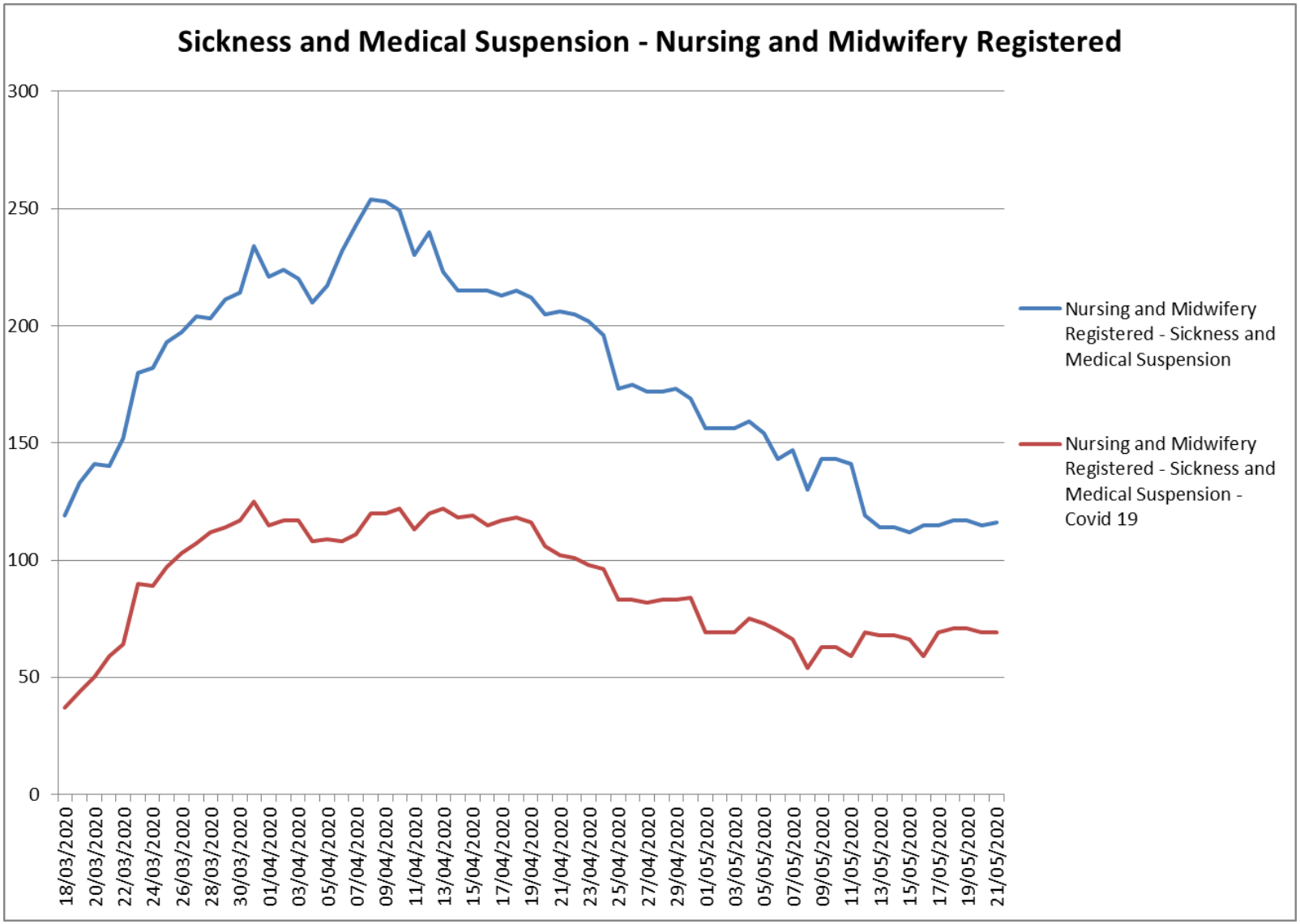
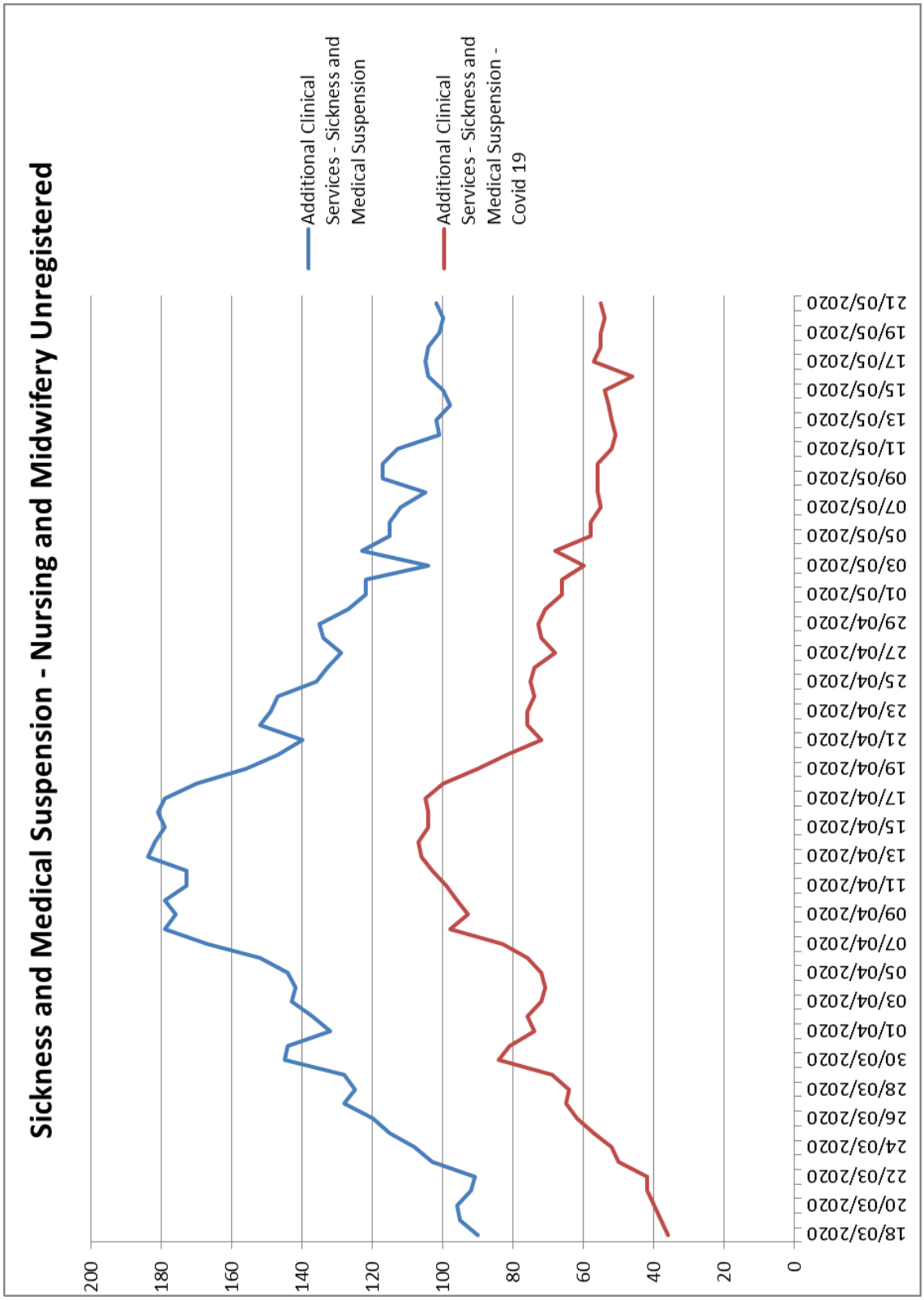
10/05/2020
12/05/2020
14/05/2020
16/05/2020
18/05/2020
20/05/2020


Sickness and Medical Suspension - Nursing and Midwifery Registered
300
250
200
150
100
50
0
18/03/2020
20/03/2020
22/03/2020
24/03/2020
26/03/2020
28/03/2020
30/03/2020
01/04/2020
03/04/2020
05/04/2020
07/04/2020
09/04/2020
11/04/2020
13/04/2020
15/04/2020
17/04/2020
19/04/2020
21/04/2020
23/04/2020
25/04/2020
27/04/2020
29/04/2020
01/05/2020
03/05/2020
05/05/2020
07/05/2020
09/05/2020
11/05/2020
13/05/2020
15/05/2020
17/05/2020
19/05/2020
21/05/2020
Nursing and Midwifery Registered - Sickness and Medical Suspension
Nursing and Midwifery Registered - Sickness and Medical Suspension - Covid 19


Sickness and Medical Suspension - Nursing and Midwifery Unregistered
Additional Clinical Services - Sickness and Medical Suspension
Additional Clinical Services - Sickness and Medical Suspension - Covid 19
200
180
160
140
120
100
80
60
40
20
0
18/03/2020
20/03/2020
22/03/2020
24/03/2020
26/03/2020
28/03/2020
30/03/2020
01/04/2020
03/04/2020
05/04/2020
07/04/2020
09/04/2020
11/04/2020
13/04/2020
15/04/2020
17/04/2020
19/04/2020
21/04/2020
23/04/2020
25/04/2020
27/04/2020
29/04/2020
01/05/2020
03/05/2020
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11/05/2020
13/05/2020
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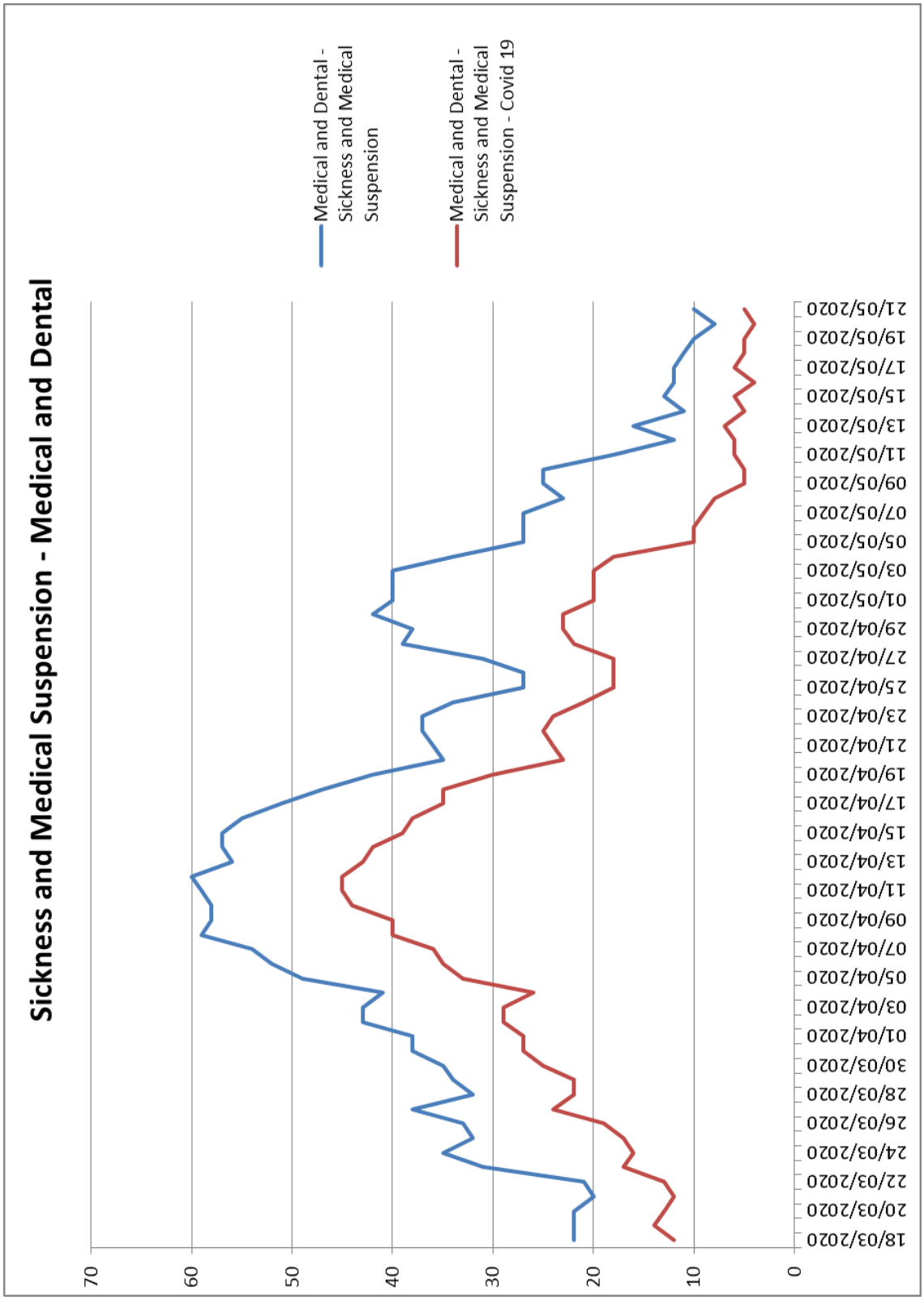
17/05/2020
19/05/2020
21/05/2020


Sickness and Medical Suspension - Medical and Dental
Medical and Dental - Sickness and Medical Suspension
Medical and Dental - Sickness and Medical Suspension - Covid 19
70
60
50
40
30
20
10
0
18/03/2020
20/03/2020
22/03/2020
24/03/2020
26/03/2020
28/03/2020
30/03/2020
01/04/2020
03/04/2020
05/04/2020
07/04/2020
09/04/2020
11/04/2020
13/04/2020
15/04/2020
17/04/2020
19/04/2020
21/04/2020
23/04/2020
25/04/2020
27/04/2020
29/04/2020
01/05/2020
03/05/2020
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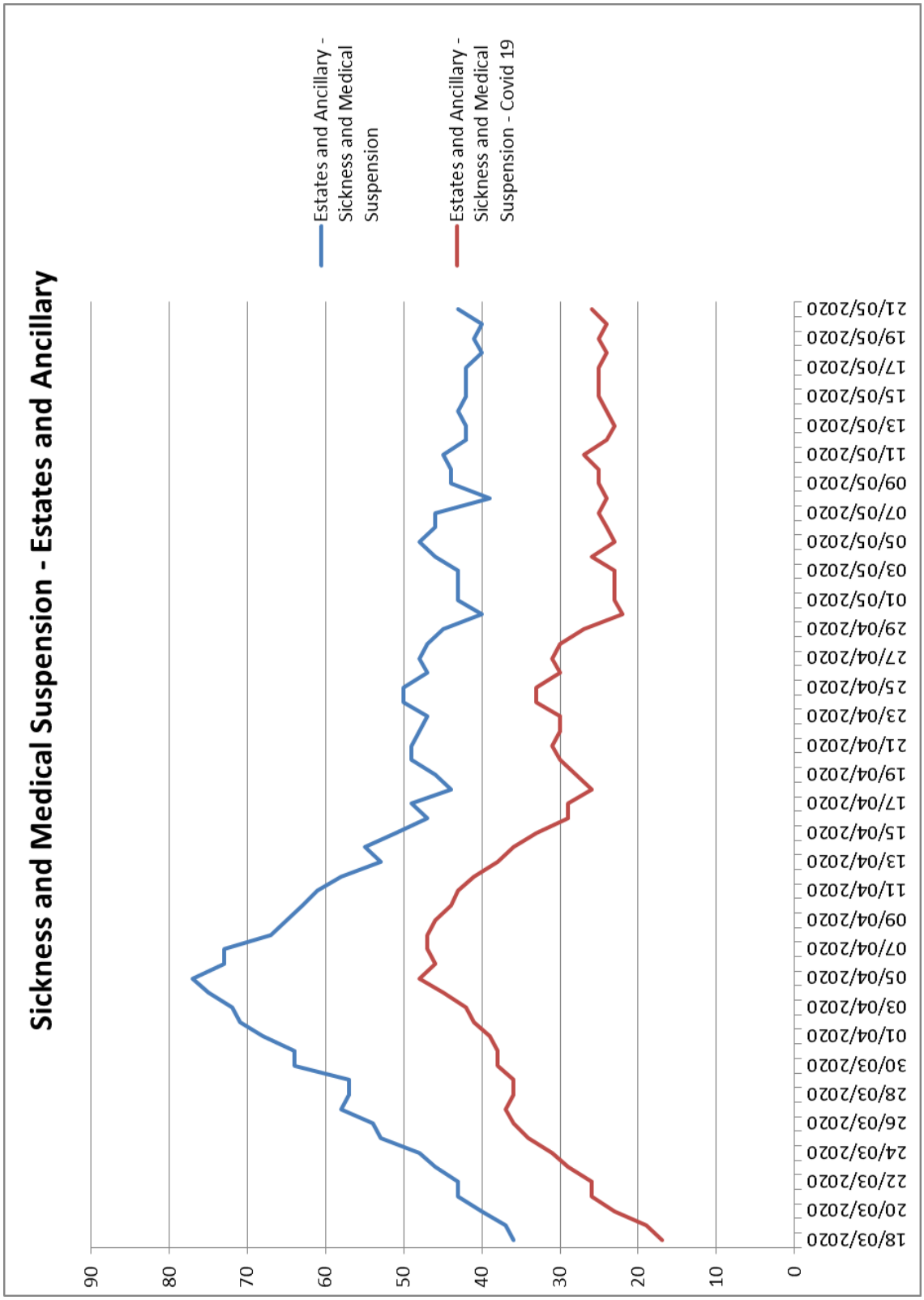
11/05/2020
13/05/2020
15/05/2020
17/05/2020
19/05/2020
21/05/2020


Sickness and Medical Suspension - Estates and Ancillary
Estates and Ancillary - Sickness and Medical Suspension
Estates and Ancillary - Sickness and Medical Suspension - Covid 19
90
80
70
60
50
40
30
20
10
0
18/03/2020
20/03/2020
22/03/2020
24/03/2020
26/03/2020
28/03/2020
30/03/2020
01/04/2020
03/04/2020
05/04/2020
07/04/2020
09/04/2020
11/04/2020
13/04/2020
15/04/2020
17/04/2020
19/04/2020
21/04/2020
23/04/2020
25/04/2020
27/04/2020
29/04/2020
01/05/2020
03/05/2020
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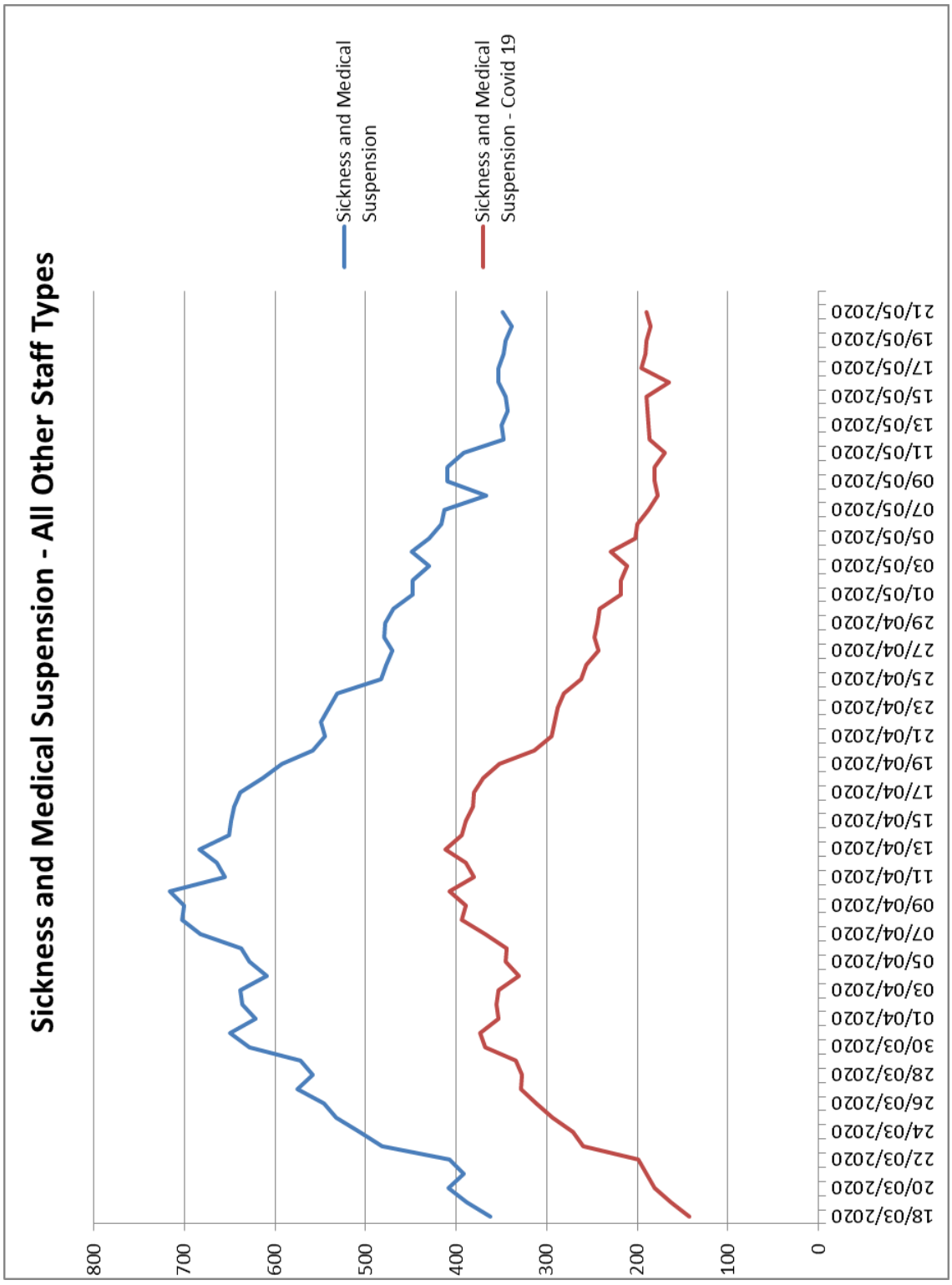
17/05/2020
19/05/2020
21/05/2020


Sickness and Medical Suspension - All Other Staff Types
Sickness and Medical Suspension
Sickness and Medical Suspension - Covid 19
800
700
600
500
400
300
200
100
0
18/03/2020
20/03/2020
22/03/2020
24/03/2020
26/03/2020
28/03/2020
30/03/2020
01/04/2020
03/04/2020
05/04/2020
07/04/2020
09/04/2020
11/04/2020
13/04/2020
15/04/2020
17/04/2020
19/04/2020
21/04/2020
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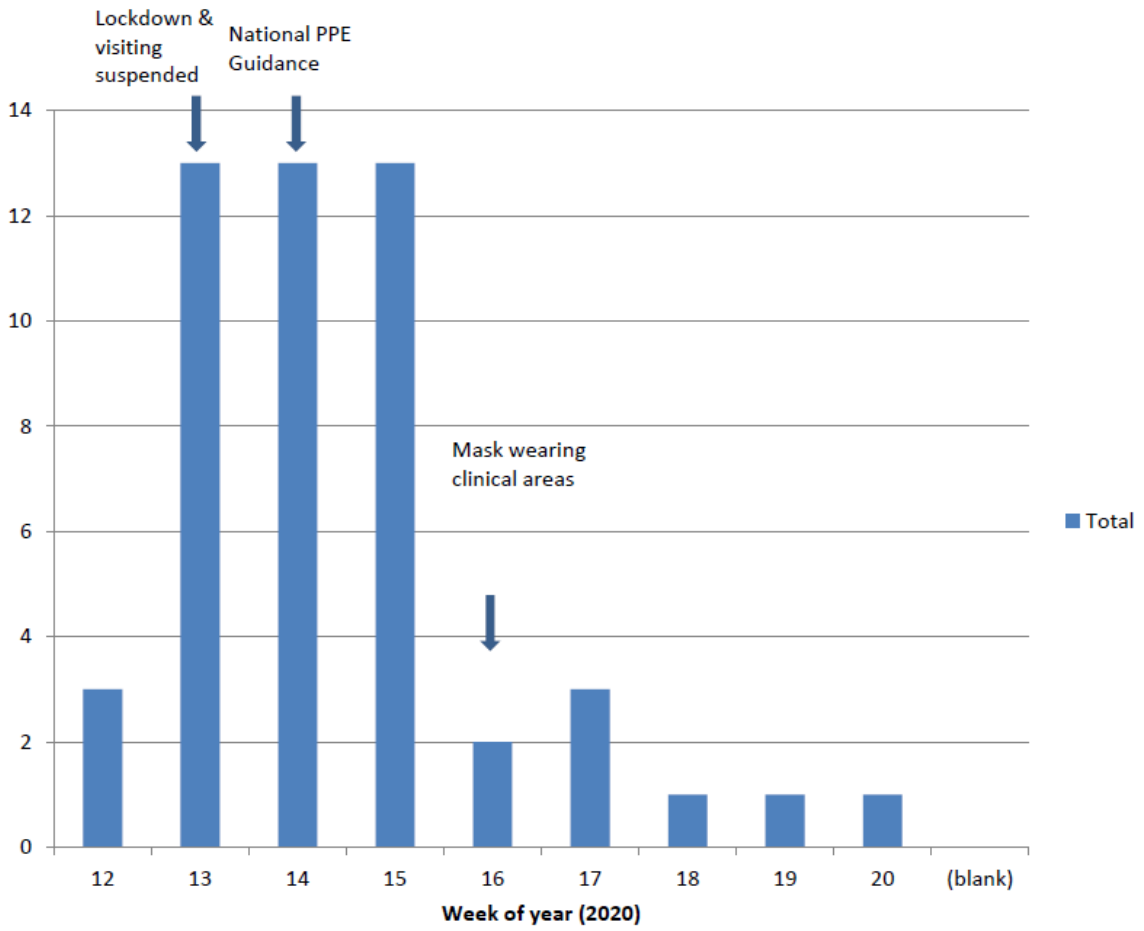
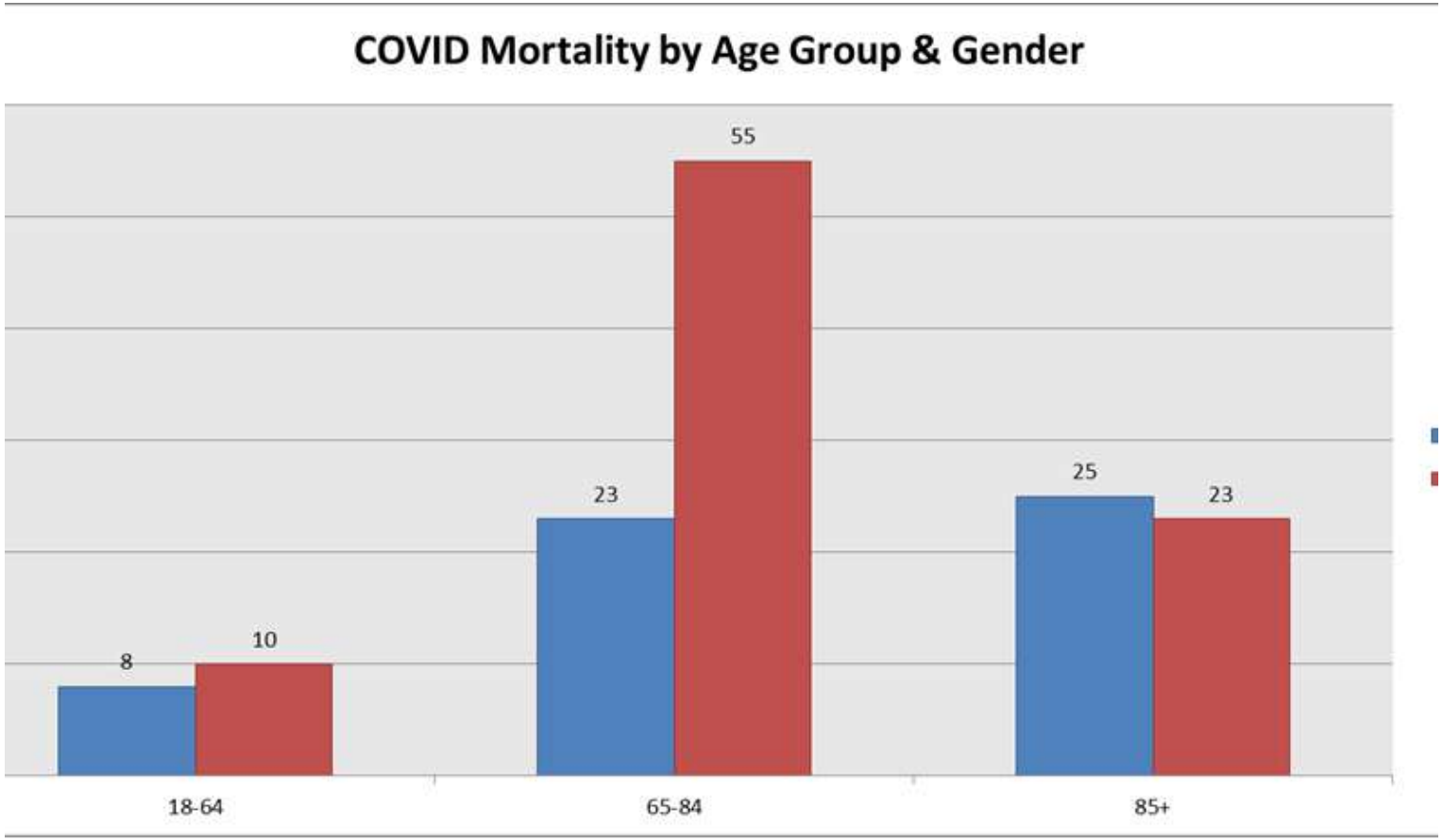
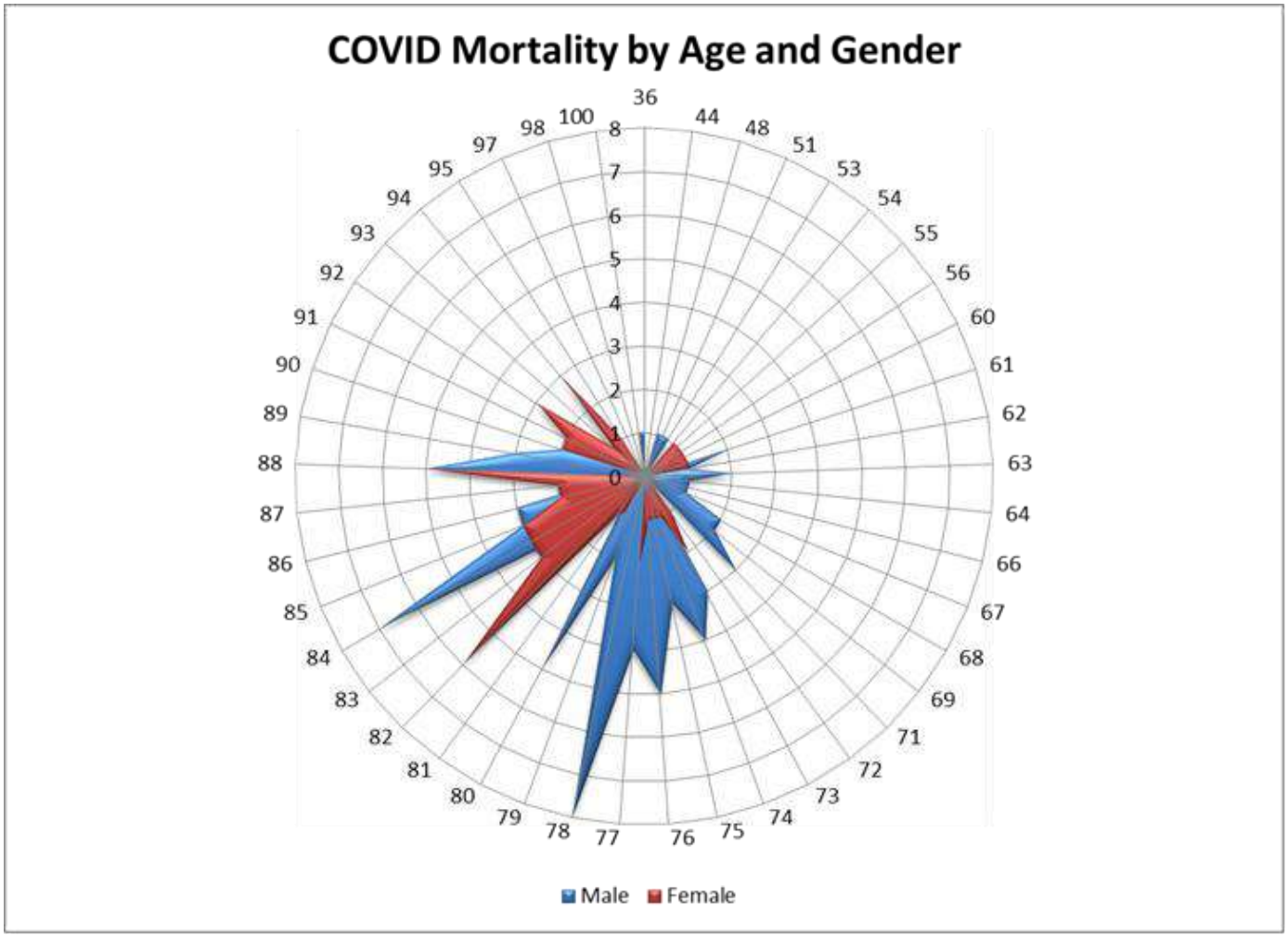


COVID-19 HAI (≥14days from admission)


COVID Mortality by Age Group & Gender
55
25
23
23
10
8
18-64
65-84
85+


COVID Mortality by Age and Gender
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92
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98
100
8
7
6
5
4
3
2
1
0
Male
Female

Of the 145 deaths ‘Covid’ positive, only 7 were under 60.

1. Female 54 presented abdominal pain. Disseminated adenocarcinoma, palliative care.

2. Male 48. SOB. Obese, wheel-chair bound alcoholic cerebro-vascular disease, dense hemiplegia and wheelchair bound.

3. Female 44. SOB. Alcoholic.

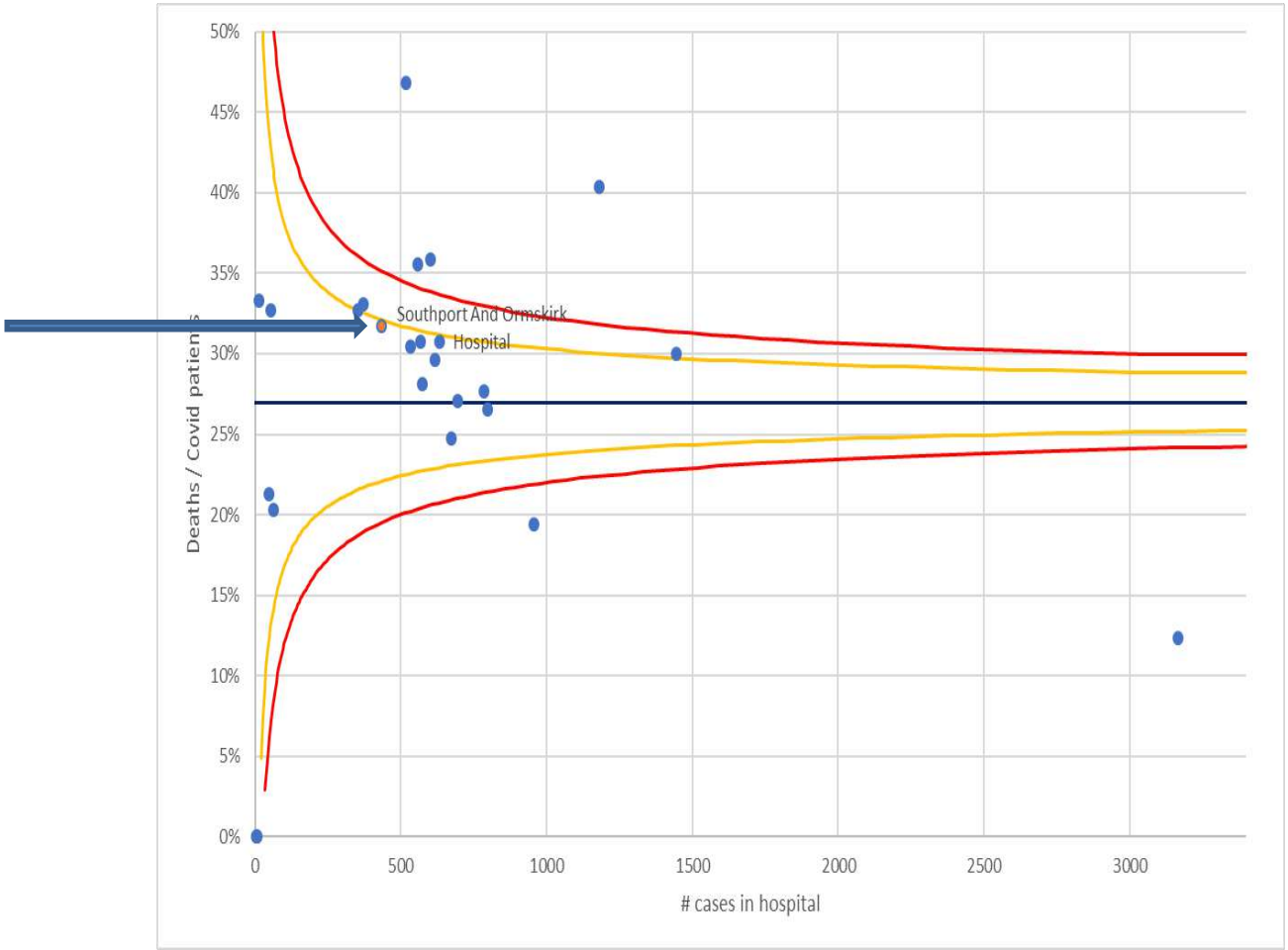
4. Male 53. SOB had recently been in patient for 3 weeks alcoholic/autoimmune hepatitis? Poor functional status.

5. Male 53. SOB. Type 2 DM

6. Female 55. Also pneumococcal positive.

7. Female 55. High BMI

Funnel plot for NW acute trusts of rate of Covid deaths against cases, as at 02 June



Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**1 July 2020**
Agenda Item	**TB119/20**	**FOI Exempt**	**No**
Report Title	**Quarter 4 Freedom To Speak Up Report and Annual Report**		
Executive Lead	Bridget Lees, Executive Director of Nursing Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides an update on concerns raised through the FTSU Service during Q4.

Executive Summary

This report identifies the number of concerns raised to the FTSU Guardian during quarter 4 2020 (1st January – 31st March). Over the quarter 21 concerns have been raised through the FTSU Service.

The Annual Report highlights that 118 concerns were raised over the year and highlights the significant improvement journey the Freedom to Speak Up Service has taken since the National Guardian's case review in summer 2017.

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

The quarter and year ended in the shadow of the Covid-19 pandemic. Nationally up to two thirds of Freedom to Speak Up Guardians were redeployed to other duties. Locally, although there was no formal redeployment, the ending of the secondment of the Freedom to Speak Up Administrator and her return to her substantive post, and the significantly higher demands on the chaplaincy and spiritual care service, effectively meant Freedom to Speak Up was less prominent. Some general concerns were raised as well as ones relating to the trust's response to Covid-19, but the number of these were down, compared to the monthly average. This may have been through lack of promotion of Freedom to Speak Up, but more likely due to the responsive accessibility of the Executives

Recommendation

The Board is asked to receive the report and note progress made during 2019-2020 and support future plans for the year 2020 – 2021

Previously Considered By:

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

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

✓ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Martin Abrams	Bridget Lees

Southport East-West Cycle Link scheme

1. Purpose

1.1. The purpose of this report is to provide the Board with legal advice on options to permit the path at the back of Southport Hospital to continue to be used as a cycle path following council works on the Trust's land.

2. Introduction

2.1. Sefton Council have been constructing a cycle path under licence on the Trust's land running by Janes Brook.

2.2. This forms part of the Council's cycle strategy and is one element of eight linked schemes to create an East-West cycle link throughout Sefton.

2.3. Sefton Council has proposed the following 4 options:

- Deed of easement
- Land transfer
- Dedicate as a Bridleway
- Permissive agreement

2.4. The Trust's solicitors, Capsticks were consulted for advice and this is shown in full in appendix 1.

3. Conclusion

3.1. Capsticks have summarised their advice at the end of appendix 1.

3.2. There are pros and cons relating to each option although they do state that the deed of easement gives the Trust the least obvious benefit.

3.3. The Board will need to make a decision based on the legal advice and whether the land forms any part of its future strategy.

3.4. Note this is a very small piece of land and is the width of a normal path running along Janes Brook.

3.5. It starts at the Scarisbrick New Road side and runs behind the hospital past the Mulbury Homes construction and the playground joining up to Town Lane.

4. Recommendations

4.1. It is recommended that the Board approves one of the four options.

Appendix 1 – Legal advice

Option 1 is a Deed of Easement which would grant the right for the land to be used for the purpose of the cycle path.

An easement would grant for the benefit of a defined part of the Council's adjoining land a right for the owner of that land on the terms of the easement to use the cycle path on whatever terms are agreed and documented in the easement. The Trust would retain ownership of the strip of land. The right would attach to the Council's adjoining land and would benefit all future owners of that land. Your land comprised in the easement (ownership of which you will retain) will be subject to this easement as a legal interest in favour of the Council's land burdening your land. The benefit of the right would pass to all future owners of the Council's land and the burden to any successive owners of the strip of land.

You would need to agree with the Council the exact terms of the easement – who can use it (likely to be a very widely defined group) and for what purpose and also maintaining and statutory compliance responsibilities (which I suggest you pass to the Council). You would also want a full indemnity from the Council for any claims made against you as owner by virtue of this use.

The advantages of this route are that you retain ownership of the area and will have control to the extent that if there are any breaches of the terms of the easement (unpermitted uses or breach of repairing liabilities) you could take action for breach (damages claim or a court injunction preventing such continued breach etc.).

The disadvantages are that by retaining ownership you retain the responsibilities that go with that but effectively have passed over control of the use to the Council and this land is only part of the overall cycle path and not the whole of it so part will be owned by the Council and part by the Trust which could be overly complex. You may prefer to hand over ownership and control and therefore relinquish your responsibility if you are certain this area is no longer required by the Trust (in any event even if it was it will be a cycle path).

If you do decide to proceed with an easement you could look at a time limited easement (i.e. for a set number of years) although this may not be acceptable to the Council. Once that period expires you could take the land back or renegotiate a further easement.

If you do decide to proceed in this way the granting of an easement may attract a value and we would recommend a valuation to determine the value you should consider is paid to the Trust for the grant of this right.

I also advise that the Council meets your legal and other professional costs in granting the easement.

Option 2 is a Land Transfer and would transfer the ownership of the land in question to the Council.

This would absolve you of any further involvement with the cycle path as highlighted above. You will need to be clear it is of no further use to the Trust and the value and amenity of the Trust's retained land is not adversely affected by the sale. It will be important to consider and rights that you may require over and along the path including whether services need to be run/used under or within the path and you may wish to impose restriction by way of restrictive covenants on how and what the path is used for (e.g. prohibiting motorised vehicles) in the future.

You would also need to consider what value the land should be sold for and it would therefore be advisable to obtain appropriate professional advice in this respect both in terms of the sale price and effect on the retained land of the sale. This will be important for audit trail and estate code compliance purposes in the event it is necessary to sell for a reduced consideration.

I also advise that the Council meets your legal and other professional costs in any transfer.

Option 3 would be for the Trust to dedicate the route as a Bridleway by a formal agreement (Sefton would do the same for the sections that it owns) and the dedication could have some limitations included, if needed.

The dedication would not alter the ownership but would make the route a public right of way, for use by walkers, cyclists and horse riders and it would be maintained by the Council.

This option would allow the intended use of the path to go ahead and would mean that maintenance of the cycle path is passed onto the Council. As a public right of way all members of the public, including the employees and users of the Trust would have similar rights to use the cycle path. The point to consider with this option is that once a public right of way is established, it will be very difficult for the trust to regain "control" of the cycle path. Therefore, if your plans and use of the retained land changes at any point, you will need to accommodate the location, size and use of the path. This could fetter your ability to develop and manage the surrounding land in the future.

This would of course also be the case if you sold the land or an easement (private right of way) was granted.

It would be important to understand what restrictions would be agreed by the Council to cover in the dedication agreement and if these would cover any concerns regarding the manner of use.

Again, your costs for the dedication should be covered by the Council.

Option 4 would involve entering into a permissive agreement with the Trust (this has been done in the past for another path through your grounds.

A permissive agreement would permit informal use of the path and you could impose conditions as appropriate and subject to being able to agree these with the Council.

This is different to an easement as it does not create a right attached to the land only a personal right in a contract granted to the Council so the benefit of this cannot be passed onto a new owner without your consent.

A permissive path agreement is often entered into on a long-term basis, but you could agree to provisions allowing you to have the ability to terminate the agreement – this detail would need to be agreed with the Council. As the agreement gives specific consent it will not be possible for a private easement to arise by long use of the right as this is only possible where no express consent is given. Signs could also be erected to make it clear that there is no intention to grant a public right of way to help reduce this risk. Use should be monitored regularly. The agreement could set out maintenance responsibilities and include indemnities similar to an easement arrangement. This option may allow you more flexibility around future use depending on the terms you can negotiate with the Council.

It may be helpful to look at the considerations which took place around the past permissive path arrangement.

Our recommendations are:

If you are satisfied you no longer need the land and there is no impact on value or amenity for your retained land in parting with ownership and control and providing you can agree to appropriate restrictions on the continued use you may decide a sale is the best option – option 2.

If you wish to retain the land and have some flexibility then a permissive path arrangement may be the preferred option – option 4.

If you wish to retain the land but pass over control and responsibility to the Council on a more formal basis and effectively relinquish flexibility around future use then option 3 should be considered.

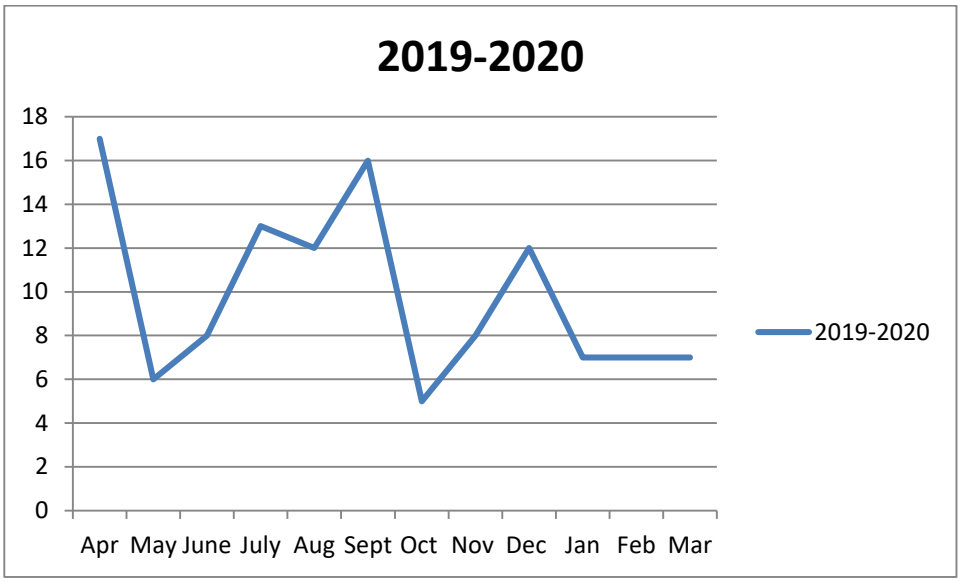
Option 4 allows more flexibility (only if the terms can be agreed which give you flexibility) but it will be important to monitor use and draft an agreement which covers liabilities and protects the Trust from more formal rights being acquired by implication.

We would suggest that Option 1 may be the option offering the least obvious benefit for the Trust.

Valuation input on amenity impact and consideration for any sale or right will be important especially for options 1-3 and the Trust should assess the effect on operations and how any estates strategy may be affected.

1 Report on Submission to National Guardians Office

Quarter 4	1st January – 31st March 2020
Date to be submitted to NGO:	**16th April 2020**
Date National Data to be published:	**TBC**
Number of concerns raised:	**21**



1.1 During quarter 4, 13 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG) and 8 were raised through FTSU Champions. When concerns are raised directly with Champions, the Freedom to Speak Up Guardian always gives support and advice, often meeting those who raise the concern, and sometimes being used in a consultative role.

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

Themes of Concerns (Quarter 4)

Relationships, alleged bullying/harassment behaviours, equality act adherence, recruitment policy adherence, car parking, space for prayers, staff safety, sexual harassment, alleged unauthorised access of medical records and various issues arising from Covid-19.

Concerns raised by a mixture of nursing, health care support and medical staff from a variety of areas. Other concerns raised by administration staff, Human Resources, Corporate, IT and Education and Training.

1.2 Anonymous concerns

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

1.3 Situations where detriment was expressed because of speaking up:

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

1.4 Feedback post raising concern

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

During quarter 4 feedback was received from 9 people. All of the feedback was positive with positive outcomes.

Given your experience, would you speak up again?

All answered yes.

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

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

We received one suggestion for improving the service which was for senior management to listen to the FTSUG more.

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

Some examples:

Thanks so much Amanda and thanks to everyone who has helped so much in making my working life feel so much safer by returning it 'back to normal'. In a heartbeat without any doubt whatsoever. You cannot improve on excellence. How can you? The way my 'case' was handled by FTSU, Execs, fellow colleagues (in my trusted circle) was above and beyond. From the start, the duty of care, constant reassurance from FTSU and feeling protected by those immediately around me who I confided in, made aware of the situation (some of whom witnessed certain incidents at various times) who safeguarded me also both when I was not aware and who I 'ran' to.

I have taken the opportunity to personally thank each and every one however the CEO said I should NOT be thanking and apologised again to me for the dreadful experience suffered by me at the hands of what was supposed to be a 'fellow colleague'. Thank you all again so very much for reinstating my safe place to work. Please do share the above with those you need to.

Yes, I think it was handled brilliantly and I felt pretty confident speaking with Martin throughout the whole thing.

Thanks for your email. Yes I would speak up again and I would like to thank the Freedom to Speak Guardian for his response, although I did not receive anything from the Infection Control Team.

Hello Amanda, yes I would definitely speak up again, I feel much more confident knowing I can come to you or Bernard anytime there is an issue or problem or if I need advice and wish I'd have done something like that sooner.

I would like to thank you for all your help, at a difficult time that I found myself in.

I am happy for my case to be closed yes. I feel content that it can be re-opened again if need be, hopefully that won't be the case though.

After my experience with raising a concern I would feel comfortable raising a concern again as I found the process and the people involved very supportive and positive. It was all dealt with in a private way which I am grateful of. I was coming into work with a lot of anxiety and dread but it was eased after sharing my feelings and raising the concern with Martin who was very understanding. My managers had a lot to do with me feeling more comfortable too.

Absolutely I would speak up again, you have both been an amazing support over recent months. Thank you both.

Of curse without a shadow of a doubt, and I would urge others with concerns to do the same!

Changes as a Result of Speaking Up:

The feedback above highlights the positive changes FTSU has made to staff. Changes in the last quarter include canges to parking system, new space for Islamic prayer being created, significant changes following concerns over staff behaviour raised, significant positive changes to a staff member's working experience following raising a concern.

Freedom to Speak Up Annual Report 2019 – 2020

Over the last year 118 concerns were raised through the Freedom to Speak up Guardians or Champions. The concerns raised have been many and varied, some offering the opportunity for a quick fix, and others more complex in nature, and because of this time consuming. The quarterly report is compiled after the data is submitted to the National Guardians Office. The quarterly reports have highlighted issues raised, staff groups raising concerns and some of the areas of change that has resulted because of this.

The quarterly reports to Board, Audit committee, Quality and Service committee and Workforce committee highlight the significance of Freedom to Speak Up within the organisation.

The Freedom to Speak Up Guardian holds regular meetings with the Chief Executive and other executives and reports to the board quarterly.

Concerns raised during the last year have included patient safety, staff wellbeing, concerns about department/environment, relationships, alleged bullying/harassment behaviours, equality act adherence, recruitment policy adherence, car parking, space for prayers, staff safety, sexual harassment, alleged unauthorised access of medical records, various issues arising from Covid-19, staffing levels, work life balance, fraud, difficulty with booking annual leave, HR processes, sickness policy, communication, dress code and whistleblowing.

Concerns over the year have been raised by a mixture of nursing, health care support, medical staff, administration staff, Human Resources, Corporate, IT, Theatre staff, members of the public, Managers, catering staff, Pharmacy, Housekeeping, Estate, Facilities, Secretaries, and Education and Training.

Feedback is always asked from those raising concerns. This is overwhelmingly positive (and reported quarterly). However a very small percentage of responses suggest there has been detriment for raising a concern This is always taken very seriously and support is given until these issues are resolved.

Recognition of CQC

The CQC Inspection Report (Published November 19) noted some very positive aspects relating to Freedom to Speak Up including the following snapshots and full statement.

All staff we spoke with knew about the trust 'freedom to speak up guardian' and the majority could name the individual. This was a national recommendation which provided an advocate and point of contact for staff to raise concerns.

Staff we spoke with were aware of the role of Freedom to Speak Up Guardian and knew who they were and how to contact them. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

The service leads promoted a no blame approach and wanted staff, at all levels, to feel empowered to be involved in change and were listened to. Speak up guardians and champions were available for staff to speak to if concerned.

On asking staff about awareness of any 'Freedom to Speak up Guardians' or champions, all of the staff we asked were fully aware of what the role entailed and how to access this service if required.

'Freedom to Speak Up' is a national integrated whistleblowing policy to help standardise the way NHS organisations should support staff who raise concerns and often the guardians for a trust will work closely with leadership teams, in supporting staff to raise concerns.

Freedom to Speak Up Guardian

The trust had a Freedom to Speak Up policy which was relevant and in date. There was a Freedom to Speak Up Guardian in post who had undergone the relevant training, had designated time for the role and was supported by 12 freedom to speak up champions. They were supported by the Director of Nursing who was the executive lead and by a designated non-executive director.

There was a process of logging all concerns raised and these were reported through the Quality and Safety Committee and to the board. There were 97 concerns raised between July 2018 and July 2019. They reported to us that the culture was changing and there was less suspicion regarding the role. They felt well supported and reported that the leadership team listened and acted upon what they heard.

In the June 2019 board meeting the Freedom to Speak Up Guardian, confirmed that the volume 20190416 900885 Post-inspection Evidence appendix template v4 Page 9 of concerns raised formally had increased within the month and throughout the year which was a positive indication of staff speaking up. There had been media coverage of a bullying culture within the Trust. There had also been evidence of learned behaviours which might have been considered appropriate many years ago but were not considered to be so now and it was acknowledged that education on "banter" was needed to address some issues.

The National Guardian Office's (NGO) action plan identified the positive work which had been achieved and the sharing of the Culture Review would soon be actioned. The National Guardian's Office (NGO) had received 7000 concerns relating to Freedom to Speak Up nationally and it was perceived that the 75 received from Southport & Ormskirk Hospital NHS Trust reflected a similar trend to other trusts. Of the 75 received, 12 had been carried over from 2018/19 to 2019/20 due to the month in which they were raised. It was however acknowledged that six had been open longer than they should have.

The FTSU team would focus on further developing listening skills and to overcome the perception that nothing would result from someone voicing their concerns or that doing so would be detrimental when considered by peers/colleagues or line managers.

Mersey Internal Audit Agency (MIAA) had conducted an annual audit of the Freedom to Speak Up Policy and the work of the FTSU Guardian and had rated the Trust's compliance as substantial assurance. 100% of staff who had been asked if they would raise an issue again via the Freedom to Speak Up route if necessary, had stated that they would.

During the last year the action plan, following the National Guardian Case Review and recommendations (published autumn 2017), in which 22 recommendations were made and an action plan containing 71 separate actions has now been completed and closed.

Freedom to Speak Up Month

Nationally, for the last two years, October has been designated as Freedom to Speak Up month. As well as national media publicity for speaking up each trust is encouraged to arrange its own local initiative. Locally we arranged *Freedom to Spook Up* (See below). Trusts within the regional network were paired together to share good practice and ideas, and we had a very helpful day at Southport with Karen, FTSUG from Salford.

Freedom to Spook Up

FTSU uses *The Meeting Place, Twitter* and *Trust News* to highlight its role and availability to support people. One awareness event, at the end of October 2019, was *Freedom to Spook Up* when a significant amount of publicity leaflets were shared and a new Champion recruited.

Staff Induction

The Freedom to Speak Up Guardian offers staff a 30 minute presentation on the principles of freedom to speak up at the monthly staff induction. There is also time offered to junior doctors as part of their induction.

Freedom to Speak Up Champions

Over the year, we have increased the number of Champions and currently have 18 active. 13 new champions were trained over the year from a wide range of areas within the hospital community. A significant change is that a number of concerns have been raised

directly with Champions. In the last quarter 8 concerns were initiated with Champions. Champions also have a key role in promoting the values of freedom to speak up and an open culture. Pictured are some of the new champions from the last year.

The National Picture

The National Guardian's Office Annual Report for 2019 was published in March 2019. The full copy of the 34 page report is available here: https://www.nationalguardian.org.uk/wp-content/uploads/2020/03/2019_ngo_annual-report.pdf

Some headlines from the report:

The speaking up culture is improving nationally. We can see this in the new Freedom to Speak Up Index, in the increasing number of cases being brought to Freedom to Speak Up Guardians and from our guardian survey, now in its third year.

The Freedom to Speak Up Index *is derived from a subset of questions from the NHS Annual Staff Survey. Of the 230 trusts, 180 - that's 78 per cent – improved their Freedom to Speak Up Index Score in the 2015-18 period with an average six percentage point increase. London Ambulance Service was the most improved trust over this timescale with an 18 percentage point increase in the index. Data is collected quarterly from guardians and published on our website. More cases are being brought to guardians.*

In the 2018-18 period, over 12,000 cases were raised, an increase of 73 per cent from the previous year. Once again many cases involved bullying and harassment which mirrors the experience of workers in the NHS annual staff survey. This year, the percentage of cases reported anonymously has fallen from 18 per cent to 12 per cent. Cases where detriment is recorded remain at five per cent and we welcome the CQC strengthening the Well Led inspection in this area.

Importantly, the data also includes details of feedback from people who have spoken up indicating whether they would do so again.

Of those that have responded, the figure for workers saying given their experience they would speak up again has consistently been around 87 per cent. Our survey of Freedom to Speak Up Guardians allows us to monitor how the role has been implemented and whether trusts are meeting our expectations. We are increasingly seeing guardians working in networks within their organisations, increasing the reach and visibility of the role. Guardians report that the Freedom to Speak Up culture in their trusts is improving and once again positive perceptions appear to be linked to the higher rating by the Care Quality Commission.

Of the 230 trusts, 180 - that's 78 per cent - improved their Freedom to Speak Up Index Score in the 2015-18 period.

Page 9

Bullying and harassment is a significant issue in NHS organisations, with a quarter of NHS staff completing the annual staff survey saying that they have experienced bullying and harassment in the last year. Working in partnership with the Royal College of Surgeons of Edinburgh and the Royal College of Obstetricians and Gynaecologists, the NGO has helped launch the Anti Bullying Alliance. This is a growing four nation alliance bringing together national bodies and grass root campaigns with the aim of tackling bullying and harassment by sharing effective interventions, case studies and expertise. Page 24

Our survey results show that Freedom to Speak Up Guardians in national bodies perceive the speaking up cultures in their own organisations need improvement. We actively encourage national bodies to reflect on how they are supporting their staff and the impact that this has on the health and care system, and the National Guardian proposes that Chairs of national bodies will also review their objectives to increase the focus on the culture of their organisation.

Guardians learn and share best practice from each other in our network for national bodies. The principles in the national guidance for Boards applies equally to non-provider organisations and we welcome the way that this has been embraced by national bodies.

The NHS has a great track record for innovation but not for implementing improvements nationally. The implementation of recommendations and actions from our case reviews by trusts across the country will further improve the culture and experience of workers. *Page 27*

19,331
cases raised to guardians in trusts over two years

(Between 1 April 2017 and 31 March 2019)

Plan for the next year

Although the year 2019/2020 closed in the shadow of Covid-19 and the many uncertainties that has created, and 2020/2021 starting with these same uncertainties, going forward there is a positive plan for consolidating and developing the work of Freedom to Speak Up across the organisation. This is all with the stated national aim of making *Speaking Up, Business as Usual.*

This is helped by the admin post now becoming a substantive, permanent position and it is hoped the person will be in post by Summer 2020.

As soon as the climate is appropriate, new Champions will be recruited and trained and the scope of Freedom to Speak Up developed further.

It was hoped to invite Dr Henrietta Hughes (National Guardian) to the organisation to see our progress during the summer of 2020. This is likely again to be postponed but hopefully the climate will be in place at some point for this to happen.

Locally we are committed to listening to people's concerns, raising these in appropriate ways, bringing to resolution and encouraging the organisation to listen and learn from the concerns raised.

As Guardian, it's been a privilege to listen to people's concerns, represent the trust at both regional and national level, learn from and take learning to other organisations as we continue to fulfil the aim of making Speaking Up business as usual.

Martin Abrams, Freedom to Speak Up Guardian, May 2020