NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA
BOARD OF DIRECTORS' MEETING

To be held at 0900 on Wednesday 02 September 2020

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
TB123/20 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB124/20 (D)	**Declaration of Directors' Interests concerning agenda items** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB125/20 (D)	**Minutes of the previous meeting** a) Meeting held on 01 July 2020 *Purpose: To **approve** the minutes of the previous meetings*	*No*	*Chair*	10 mins
TB126/20 (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**
TB127/20 (D)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	5 mins
TB128/20 (D)	**Chief Executive's Report** *Purpose : To **receive** an update on key issues from the Chief Executive Officer*	*No*	*CEO*	5 mins
OPERATIONAL AND FINANCIAL PERFORMANCE				**0920**
TB129/20 (D)	**Finance, Performance and Investment AAA Highlight Report** *Purpose : To **receive** the summary report for information and assurance*	*No*	*Cttee Chair*	5 mins
TB130/20	**Integrated Performance Report (IPR)** *a) Performance Summary*	*No*	*COO DOF*	15 mins

(D)	*b) Quality* *c) Operations* *d) Finance Performance* *e) Workforce* *Purpose: To **receive** the IPR for assurance.*			
WORKFORCE				**0940**
TB131/20 **(D)**	**Workforce Reports** a) Committee AAA Highlight Report *b)* Performance Report *Purpose: To **receive** the reports for information and assurance.*	*No*	*Cttee Chair* *DoHR*	15 mins
QUALITY & SAFETY				**0955**
TB132/20 **(D)**	**Quality and Safety Reports** a) Committee AAA Highlight Report *b)* Performance Report *Purpose : To **receive** the reports for information and assurance*	*No*	*Cttee Chair* *DoN/MD*	15 mins
TB133/20 **(D)**	**Infection Prevention and Control Assurance Framework** *Purpose :* To **receive** the IPC Assurance Framework	*No*	*DoN / MD*	5 mins
RISK AND GOVERNANCE				**1015**
TB134/20 **(D)**	**Audit Committee AAA Highlight Report** *Purpose : To **receive** the report for information and assurance*	*No*	*Cttee Chair*	5 mins
TB135/20 **(D)**	**Committee Terms of Reference** *Purpose: To **approve** Board Committee Terms of Reference*	*No*	*ADCG*	5 Mins
ITEMS FOR INFORMATION				**1025**
TB136/20 **(D)**	a) Annual Resuscitation Report b) Infection Prevention and Control Annual Report c) Health and Safety Annual report *Purpose: To **receive** and **note** the annual reports*	*No*	*DoN* *DoN* *DCEO/DoS*	10 mins
TB137/20 **(D)**	**Sefton Early Help Strategy and Children Plan** *Purpose: To receive the report*	*No*	*DCEO/DoS*	10 mins
CONCLUDING BUSINESS				**1050**
TB139/20 **(V)**	**Questions from Members of the Public**		*Public*	*5*

	*Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*mins*
TB140/20 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*	*Chair*	*3 mins*
TB141/20 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	***Chair***	*2mins*
	Date and time of next meeting: • Virtual Annual General Meeting Wednesday 16 September • **0900, Wednesday 07 October 2020**		***1100 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

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Register of Interests Declared by the Board of Directors as at 27 August 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**
BOTTOMLEY, Mrs Yvonne	Interim Director of Finance	**Emmett Cannell Consulting Limited** **Unity Theatre Liverpool**	**Emmett Cannell Consulting Limited**	**Emmett Cannell Consulting Limited**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**24 August 2020**
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**

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CHRISTIAN, Mr Steven	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**27 February 2020**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Nil**	**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 **Public Health England**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**24 August 2020**

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						Clinical Case Worker (bank) 2020 to date				
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**
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**

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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**

Southport and Ormskirk Hospital NHS Trust

Draft Minutes of the Board of Directors' Meeting
held on Microsoft Teams
Wednesday 01 July 2020
(Subject to the approval of the Board on 02 September 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 Graham Pollard	Non-Executive Director
Mr Gurpreet Singh	Non-Executive Director

In Attendance

Rev Martin Abrams	Freedom to Speak Up Guardian *(item TB119/20 only)*
Mr Richard Boydell	Deputy Head of Information *(item TB112/20 only)*
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
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance
Mr Kevin Walsh	Deputy Director of Finance

Apologies

Mr Steve Shanahan	Executive Director of Finance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		

TB102/20 Chair's Welcome and Note of Apologies

Mr Masom welcomed all in attendance advising that the Livestream of the Board meeting had been deferred to September as the Trust was recovering from the IT issues that had been experienced the previous day. The Board noted apologies for absence from Mr Shanahan.

TB103/20 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.**

TB104/20 Minutes of the previous meeting held on 06 May 2020

The Board reviewed the minutes of the meeting held on 03 June 2020 and approved them as a correct and accurate record of proceedings subject to the following amendments:

- Minute ref. TB093/20 to be revised to read "Mrs Gorry requested some

clarification on this point. Previously when discussed the EPMA model was considered suitable and it is now suggested that this will no longer be suitable, and questioned why?"

- Minute ref TB093/20 to be revised to read "and the affect that this would have on the medicines management work programme."

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

TB105/20 Matters Arising and Action Logs

There were no matters arising.

The Board considered updates which reflected progress made in discharging outstanding and agreed actions.
TB068/20 (part 1) – Status update amended. July Update – To be presented first at July's FP&I committee then to September Board. BRAG status was amended to Amber

PB089/19 (part 2) – BRAG status was amended to Blue

STRATEGIC CONTEXT

TB106/20 Chair's Report

Mr Masom advised further to discussions at the previous Board around enabling the proceedings of the Trust to be conducted in the absence of the Chair, elections had taken place to appoint a Deputy Chair in line with the Trust's Standing Orders. He announced that Dr Bricknell had been elected as the vice chair of the Board following elections. He thanked members for their nominations and in particular thanked Mr Birrell for putting his name forward as well.

Mr Masom provided a brief overview of the activities he had undertaken since the previous meeting which included the following:

- updates following a catch up call with regional system partners regarding strategy and the next steps.
- an update on the North West region's approach to an integrated care pathway for elderly care
- Regional proposals for effectively managing patient flow within Urgent and Emergency Care department.
- Participation at the first 1st Cheshire and Mersey Chairs' call, chaired by Mr Yates. It was expected that the calls would become more regular and would eventually replace North West regional with the easing of calls the Level 4 Control and Command role.

RESOLVED:
The Board **received** the Chair's update.

TB107/20 Chief Executive's Report

Mrs Armstrong-Child presented a summary report of the specific activities and issues that had occurred in the organisation since the last Trust Board meeting. She commended members of staff and patients for their support and involvement in a major research development in the fight against

Covid-19.

In addition to events highlighted within the report, the following key points were noted:

- Cheshire & Mersey was in the process of moving towards developing a system wide Patient Treatment List (PTL) In response to the Phase 2 Recovery Plan. It had been noted that the Trust had performed well in effectively managing its waiting lists.
- There was an increase in the number of ED attendances and work to reduce this by offering alternative options to patients was ongoing. NHSI had requested that additional preparatory measures to be put in place in readiness for the relaxation of the lockdown restrictions on 4 July 2020.

The Trust was waiting on the outcome of the capital bids that were submitted as part of Phase 3 which included requests around the capital works and additional IT support to enhance agile working. The team was invited to interview with NHSI to ensure that the bids submitted met the smart requirements that were provided and were complimented on the measured approach taken.

In response to a question, Mrs Armstrong-Child advised that the Trust had committed to providing free parking as well as free meals to staff for 4 months and that this period would finish at the end of July. It was noted that the directive around suspending car park charges had been made at a national level and the Trust along with system partners had agreed to await a decision before reintroducing charges.

Mr Singh thanked Mrs Armstrong-Child for a very comprehensive report. In response to Mr Singh's question around the plans for Cancer long waits, Mrs Armstrong-Child advised that a paper would be presented at the next Finance, Performance and Investment Committee (FP&I) outlining these plans.

With regards to funding allocations, Mrs Armstrong-Child commented that the Trust was unable to use underspend on revenue against capital expenditure requirements as these were separate funding streams.

In response to Mr Pollard's question around how the Trust was preparing for the possibility of a regional lockdown without prior notice, Mrs Armstrong-Child advised that the Trust has an outbreak management plan as well as contingency plans in place and these had been discussed with the CCG. A desktop exercise would be carried out in the next few days based on these plans.

ACTION: Mrs Armstrong-Child to include an overview of the Cheshire and Mersey plan at the Trust Board meeting on 02 September. **CEO**

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

Risk and Governance

TB109/20 Board Assurance Framework

Mrs Armstrong-Child presented an update on the Board Assurance Framework (BAF) advising that this had been reviewed during Q2 by the accountable Executive Directors. She acknowledged that the revision and refresh of the BAF had not progressed at pace but work on formatting the document which would include a refresh of the wording around risks and risk appetites.

Mrs Armstrong-Child committed to provide an updated BAF to the Board at the end of quarter 2 for discussion. She outlined that an electronic survey would be circulated to Board members to canvass opinions around the current and proposed versions of the document.

Mrs Gorry expressed concern that the risk appetite had not been revisited adding that there was a need for the Board to carry out additional work in order to achieve a level understanding of risk appetite. Mr Masom added that risk appetite would normally be reviewed at the Board annually and this was presented for the first time last year.

Mr Birrell commented that the BAF should provide assurance on the delivery of the Strategic Objectives but in its current form, the document was more focused on what was not being delivered. Mr Birrell also advised that the Audit Committee was planning to carry out assurance mapping work which would complement the BAF.

Adding to Mr Singh's comments regarding the format of the BAF to be easy to read and understand, Mrs Gibson acknowledged that the Board was making good progress but an understanding of what will provide assurance is needed along with the key actions needed to achieve this.

Dr Bricknell commented that it is good to retain a similar format and to include background information where possible.

ACTION: A review of the risk appetite statement would be undertaken at the October Board meeting. **CEO**

RESOLVED:
The Board **received** the updated Board Assurance Framework

TB110/20 Corporate Risk Register

a) Extreme Risk Register

Ms Lees presented the Extreme Risk Register advising that following a review by the Risk and Compliance Group, three risks remained on the Register. She drew attention to the chart included in the report which sought to alleviate concerns around risk stagnation. The Risk Register was becoming more dynamic and would correlate with the BAF going forward.

It was noted that the Nurse Staffing risk remained on the register. However, there was a need to further review the rating given the mitigations in place through the provision of temporary staffing arrangements to fill the vacant posts. It was highlighted that the Trust needed to assess how these roles could be filled on a permanent basis.

The Board noted the addition of the new risk relating to Fragile services and requested a revision of the risk rating as it seemed low.

With regards to the Clinical Competence risk, it was noted that this had been reviewed at the Risk and Compliance Group meeting and remained the subject of discussions at the Executive Team Meeting (ETM). It was expected that the current risk would be split to reflect the separate issues and the wording would be revised so it could better articulate the risk.

With regards to a query around engagement from the CBUs, Mrs Armstrong-Child advised that attendance at the monthly Risk and Compliance Group had significantly improved and, she was confident that there was sufficient engagement from the CBUs.

b) Covid-19 Risk Register

Mrs Katema advised that the Covid-19 Risk Register continued to be reviewed at Gold Command on a weekly basis. The Digital service risk would be reviewed in light of the previous day's incident. The updated risks would be presented to both Gold Command and ETM for discussion. Furthermore, Mr Chadwick, (Head of IT) had been invited to attend the Gold Command meetings going forward.

It was noted that this would be the final time a separate Covid-19 Risk Register would be presented as work to amalgamate the registers into a single document was progressing.

RESOLVED

The Board **received** the Risk Registers

PERFORMANCE AND GOVERNANCE

TB111/20 Finance, Performance and Investment Committee

Mr Pollard presented the AAA Highlight report and the minutes from the Finance, Performance and Investments Committee held on 22 June 2020. He drew attention to the two Alerts relating to the lack of progress around the Cost Improvement Plan (CIP) and the Referral to Treatment (RTT) 52 week standard.

The meeting had discussed the underspend across both the general and Covid-19 budgets. The Committee had expressed concern that there was a need for clarity and better understanding of how the Trust is performing against the previous year and had requested that the Executive team review this and provide feedback. Mr Walsh will review this and provide feedback at the next FP&I Committee meeting.

Mr Masom commended the Trust for achieving good operational performance during Covid-19 whilst noting concerns around the long waiters.

RESOLVED:

The Board **received** the minutes and AAA Highlight report from the

Finance, Performance and Investment Committee.

TB112/20 Integrated Performance Report (IPR)

Mr Boydell joined the meeting

Mrs Armstrong-Child presented the update on the Trust's performance against key national and local priorities. It was noted that performance indicators were grouped according to the domains used by regulators in the Well Led Framework with each indicator detailing the Statistical Process Control (SPC) chart and commentary.

a) Quality

Ms Lees provided a brief overview of the quality indicators and advised that:

- a new process around the accountability framework for Harm Free Care had been introduced and discussions would form part of the monthly Performance, Improvement, Delivery and Assurance Boards (PIDA).
- Ms Lees had commissioned a peer review due to the increase in pressure ulcers. The Infection and Prevention Control Annual Report which was scheduled to be presented at the next meeting would provide an update around C-Diff. It was noted that Covid-19 had taken precedence in the IPC area in recent months.

There had been an improvement in the Fractured neck of femur however there are issues around theatre turnaround and an additional trauma list had been booked in June to improve the situation.

In response to Acute Kidney Injury (AKI) being highlighted as a significant outlier, the meeting was advised that this related to a small proportion of patients aged between 81 to 92. However, the patients who passed had multiple morbidities and based on this information further analysis would be undertaken with a view to improve the initial recordings of AKIs going forward.

The temporary suspension of the paper based Friends and Family Test due to concerns around infection control had impacted on the response rates. An electronic version had now been introduced and there should be an improvement in the response rate.

The newly introduced Ward Dashboard had been embraced positively by the Matrons and ward staff.

In response to Mrs Gorry's question around the accuracy of the data, Mr Boydell advised the meeting that this is a dynamic document and this could result in different data being provided at the Quality and Safety meeting and the Trust Board and that this will need to be discussed.

Mr Birrell expressed concern about the increased number of pressure ulcers and C-Diff cases and also asked why the Trust's caesarean and induction rates are consistently above target. Ms Lees responded that, whilst there had been an increase in pressure ulcers, the Trust was not considered an outlier in this area. With regards to the increase in

induction rates in maternity, it was noted that there were clinical reasons to support the inductions and that there had been a decrease in the number of still births.

MD

ACTION: Dr Hankin to provide assurance at next meeting around AKI patients.

b) Operational Performance

Mr Christian outlined that Trust's Emergency Department had consistently met the 4hour national standard during the previous two months. The Trust had moved out of the bottom quartile to the upper quartile and was ranked amongst the top Trusts nationally for the two week period preceding the meeting. Mr Christian advised that the improvements made could be linked back to the service improvement initiatives that were put in place over the last 12 months and were now fully embedded as good practice and improved patient care. In terms of the next steps, Mr Christian outlined that there would be an increased focus on planning for winter with Covid-19, which would include the possible introduction of Seacole beds as well as engaging with the care home market to enhance care and minimise admittance to hospital. This would require reconfiguration of existing Winter plans to prevent corridor care.

It was noted that despite a reduction in the National 62 day cancer performance this month, the Trust had maintained good performance in this area. The Trust has engaged with a regional group and was currently treating patients based on risk and not time frames.

There has been a reduction in performance around the RTT rate and an increase in the number of long waits. The single breach recorded during April had been down to patient choice and the required adherence to the 14 day isolation period.

The extended arrangements with Renacres to the end of August 2020 would allow surgical specialities the opportunity to use this estate and support the recovery plans. The impact of national guidelines around PPE and social distancing on productivity would be reviewed.

The theatre list at Ormskirk had been increased by an additional four slots per day and this will help with the recovery.

c) Finance

Mr Walsh presented the Finance section advising that a number of the metrics included in the Finance section were based on March data as the Trust was operating under a new financial framework in the response to Covid-19 and the existing metrics were not relevant anymore and/or were not being monitored.

d) Workforce

Mrs Royds presented the Workforce indicators advising that completion of PDRs remained an area of concern for the Workforce Committee. A review of core mandatory training was underway with a view to safely re-instating face to face training in those areas where no alternative solution

had been found. A clinical education review is also being undertaken to put in place a clinical skills programme which will be supported by a full training needs assessment (TNA) and the appropriate resources/team structures to deliver it.

The Board thanked Mr Boydell for the work undertaken on the IPR and for attending the meeting.

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

(Mr Boydell left the meeting)

TB113/20 Finance Report including

Mr Walsh presented the Finance Report which detailed the financial position for Month 2 and provided the context around the financial arrangements that were in place for the period April to July 2020. He advised that whilst the financial framework was being revised for the period 01 August 2020 to 31 March 2021, an update would be provided through FP&I on receipt of further guidance. Overall the Trust was currently performing well financially and expenditure was lower than the plan set by the Regulator. Furthermore, compared to the other Trusts, the Covid-19 spend was not excessive. It was noted that Deloitte had been appointed to audit the Covid-19 spend of all Trusts.

The elective programme had been stood down for the first two months of the financial year which had resulted in a reduction in non-pay spend and this contributed to the Trust's good performance. However, these costs were forecast to increase with the resumption of elective programs but could be offset by a decrease in Covid-19 spend as the impact of the pandemic reduces.

Mrs Armstrong-Child advised that the capital budget had been signed off last week. The Estates team will be looking at various ways to carry out capital work safely.

Mr Walsh outlined that the Trust would receive in due course guidance around available spend for the remainder of the financial year. It was expected that the financial envelope within which the Trust would need to operate would take into account the spend at the start of the year as well as Covid-19 spend. The Trust would need to have cost saving schemes ready to be implemented so that these costs could be removed from the system in order to achieve the expected financial settlement. A detailed review of potential CIP schemes would be undertaken to gain an understanding of whether these could be implemented in the remainder of the financial year.

There was a need to understand the level of expenditure going forward and normally this would be based on earned value metrics. Mr Pollard was asked to discuss with Mr Walsh the practicality of using earned value measures as a way of better understanding the underlying financial position.

ACTION: Mr Walsh and Mr Pollard to review earned value measures. **DoF**

RESOLVED
The Board **received** the finance report for discussion and assurance

WORKFORCE

TB114/20 Workforce Committee

Mrs Gibson presented the AAA Highlight Report and the minutes of the meeting held on 23 June.

It was noted that the Trust would be performance managing the NHSP contract. Additionally, the Medical dental workforce job planning, cost, implications and review may require a formal appeal process.

In response to the concern around data being presented within the IPR, Mr Masom queried if this could be picked up as part of the ongoing work with IPR. Mrs Armstrong-Child advised that, to ensure there was consistent process with data that was presented to the Board and Committees, the Business Intelligence team would look at the integrated dashboard to have a single cut-off date and an audit trail showing the data sources. This would form part of the work being undertaken by Mr Boydell and the Business Intelligence team and would be included in the next iteration.

It was noted that the PDR compliance had reduced again this month and it has been agreed that this will be one of the recommended areas of focus going forward. The Committee will be commissioning a deep dive exercise into PRD compliance.

ACTION: The Terms of Reference will be presented at the August WFC for agreement. **DoHR**

RESOLVED:
The Board **received** the minutes and the AAA highlight report from the Workforce Committee.

TB115/20 Safe Nursing & Midwifery Staffing Report (bi-annual report)

Ms Lees presented the Bi Annual Staffing Establishment review which provided a comprehensive update on nurse and midwifery staffing, mainly focusing within the inpatient bed base areas within the Trust over the previous six months. This was the first time that this report was presented in this format.

Ms Lees provided an overview of the report advising that the Trust was now working closely with Partnership Health Education and local Universities and this has resulted in an increase in students by 50%. Whilst this supported the recruitment drives, the Trust was also reviewing ways to improve the retention of these students. .

In response to Mrs Gorry's question around the NHSEI Interim People Plan, Mrs Royds advised that the final plan had been delayed due to Covid-19 with further guidance expected towards the end of the year.

Mr Birrell said that complex reports such as this one would benefit from the inclusion of an executive summary. He also commented that it would be helpful if future bi-annual reports could include nurse specialists and non-ward based nurses so that a comprehensive assessment can be undertaken. Ms Lees recognised that affordability had to be borne in mind. It was important to ensure that ward establishment was clearly defined. Different models and paths of care were reviewed to see how the Trust could deliver differently.

In response to Mr Pollard's comment about the 5,000 additional placements being made available nationally Ms Lees advised the meeting that the Trust, by working with UCLAN and Edge Hill, have submitted a bid.

RESOLVED:
The Board **received** the Safe Nursing and Midwifery Staffing Report

QUALITY & SAFETY

TB116/20 Quality and Safety Committee

Dr Bricknell presented the AAA highlight report and minutes of the Quality and Safety Committee held on 26 May 2020. He outlined that there was a common thread across all committees around inconsistencies with data. Ms Lees commented that the work that was being carried out with the Perfect Ward app would provide more comprehensive and understandable reports going forward. With regards to the concerns around mandatory training, it had been agreed at the Quality and Safety Committee that the breakdown of mandatory training would be included as a standing agenda item at each meeting.

RESOLVED:
The Board **received** the minutes and the AAA highlight report from the Quality and Safety Committee.

TB117/20 Quality and Safety Reports

a) Quality Improvement Plan
Ms Lees presented the report which provided an update on the progress of the Quality Improvement Plan across each of the following quality priorities:

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

It was noted that the overhaul of the Quality priorities would be complemented by a Quality Improvement structure.

Dr Hankin confirmed that he has had discussions around the trigger score for "On Time Observations" and needs to understand how to integrate this data.

b) CQC Progress
Ms Lees presented the CQC progress report which detailed progress,

governance arrangements and provided assurance that processes were in place to ensure there was a continuous cycle of sustainable improvement. She outlined that the team was currently building robust assurance processes which would be evident to the Board going forward.

In response to Mr Pollard's question around "On Track to Deliver", Dr Hankin advised that the business case had been rejected and staff had been challenged to look at other working practices to resolve this.

c) Medical Director's Covid-19 Presentation

Dr Hankin presented the Medical Director's Covid-19 report highlighting that the excess in mortality rates could be directly tracked to Covid-19. It was noted that of the 145 recorded deaths from Covid-19 positive patients, seven patients were under the age of 60 and the report provided a breakdown of these patients.

The Board discussed the report noting the challenges that there were in breaking down data into specific age groups and ethnicities which were further compounded by the challenges in the distribution of the local population data as the data was being captured nationally.

RESOLVED:
The Board **received** the Quality and Safety updates

TB118/20 Infection Prevention and Control Assurance Framework

Ms Lees presented the Infection Prevention and Control (IPC) Assurance Framework advising that in May 2020 all organisations were advised by NHSEI to ensure the Trust had the right structure in place to deal with Covid-19. The IPC Assurance Framework had been presented at Gold Command and included an audit programme to ensure that evidence was in place to provide this assurance. It was noted that two cases of Covid-19 were deemed to be an outbreak and the Trust was required to have a robust plan in place to deal with any potential outbreaks.

The Board was advised that an updated Infection and Prevention Control Assurance Framework would be presented at the next Board meeting.

RESOLVED:
The Board **received** and noted the Infection Prevention Control Assurance Framework

ITEMS FOR APPROVAL

TB119/20 Annual Freedom to Speak Up Report

Rev Abrams joined the meeting.

Rev Abrams presented the Annual Freedom to Speak Up Report which provided an overview of concerns raised to the Freedom to Speak Up Guardian (FTSUG) throughout the year and included a summary of concerns raised during quarter 4 2020. Of the 118 concerns raised over the year, 21 concerns had been recorded during the quarter. Whilst no

anonymous concerns had been raised over the last quarter, a number of people were unwilling to have their names known. It was noted that there had been a decrease in the number of concerns raised, both locally and nationally, during the pandemic.

The Board considered the report and commended the FTSUG for the progress made in addressing concerns and acknowledged that there was a need to continue building on the successes.

In response to Mrs Gorry's question regarding the correlation between successes noted in the report and improvements in the staff survey, Rev Abrams advised the meeting that he had only started to work on this just before Covid-19 and would provide feedback once completed.

RESOLVED:
The Board **received** and noted the annual report

Rev Abrams left the meeting

CONCLUDING BUSINESS

TB120/20 Questions from Members of the Public

It was noted that no questions were received from members of the public.

TB121/20 Message from the Board

The Board agreed the messages to be circulated across the organisation.

TB122/20 Any Other Business

The Board agreed that engagement with the community was vital and noted that whilst the meetings had not been open to the public due to visiting restrictions, plans were in place to ensure that they could join the meeting via Livestream. It was noted that the board packs continued to be published on the website and Mrs Armstrong-Child had maintained regular contact with local MPs

In response to a question regarding assuring the wider community that it was safe to attend hospital appointments, Mrs Armstrong-Child advised that the Trust could not provide absolute assurance but steps were in place to mitigate the risk to patients contracting Covid-19 adding that patient safety remained of paramount importance.
There being no other business, the chair thanked all for attending and brought the meeting to a close at 1245.

Board Attendance 2020/21												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓	✓	✓	√								
Trish Armstrong-Child	✓	✓	✓	√								

Southport and Ormskirk Hospital NHS Trust

Jim Birrell	✓	✓	✓	√								
David Bricknell	✓	✓	✓	√								
Bridget Lees	✓	✓	✓	√								
Julie Gorry	✓	✓	✓	√								
Terry Hankin	✓	✓	✓	√								
Therese Patten	✓	✓	✓	√								
Graham Pollard	✓	✓	✓	√								
Steve Shanahan	✓	✓	✓	A								
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 27 August 2020

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 and then at Board in Sept. **Aug Update :** Not complete. Interim DoF to complete self-assessment for September FP&I Committee.	**Red**
TB088/20	03 June 2020	**Finance, Performance and Investments Committee**	The Executive Team to provide an update to the Board through FP&I 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**
TB107/20	July 2020	**Chief Executive Report**	Mrs Armstrong-Child will present an overview of the Cheshire and Mersey plan.	**CEO**	Sept 2020	Sept 2020	**July Update :** Update will be presented at the September meeting.	**On Agenda**

BOARD OF DIRECTORS (Part 1)
Action Log updated 27 August 2020

NHS Southport and Ormskirk Hospital NHS Trust

TB109/20	July 2020	**Board Assurance Framework**	A review of risk appetite to be undertaken at the next Board meeting	**CEO**	Sept 2020	Sept 2020	**July Update:** Will be reviewed at the October meeting.	**Green**
TB112/20	July 2020	**Integrated Performance Report (IPR)**	Dr Hankin to provide assurance at next meeting around AKI patients	**MD**	Sept 2020	Sept 2020	**July Update:** Assurance will be provided at September meeting **August Update:** Dr Hankin will provide verbal update at September meeting	**Green**
TB113/20	July 2020	**Finance Report**	Mr Walsh and Mr Pollard to review earned value measures.	**DoF**	Sept 2020	Sept 2020	**July Update:** Will be discussed **August Update** : Meeting to be arranged and the Interim DoF to be included in the meeting invite.	**Amber**
TB114/20	July 2020	**Workforce Committee**	Workforce Committee (WFC) has commissioned a Deep Dive exercise into PDR compliance	**DoHR**	Sept 2020	Sept 2020	**July Update:** Terms of Reference will be presented at August WFC for agreement **August Update:** Terms of Reference were discussed and amendments suggested at August WFC in order for Deep Dive to commence. **Action Completed**	**Blue**

BOARD OF DIRECTORS (Part 1)
Action Log updated 27 August 2020

NHS 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**
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. **July Update:** Included on Agenda for July meeting	**BLUE**
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** **July Update:** Included on Agenda for July meeting	**BLUE**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 September 2020**
Agenda Item	**TB127/20**	**FOI Exempt**	**No**
Report Title	**CHAIR'S REPORT**		
Executive Lead	Neil Masom, Trust Chair		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update to the Board of Directors on the activities undertaken by the Chair since the last meeting.

Executive Summary

This report advises the Board of Directors of the Chair's activity since the previous meeting in relation to:

- North West Regional and Cheshire and Mersey Chairs' Meetings
- System by Default
- Personal Activity in the Trust
- Charitable Funds
- Acute Sustainability Strategy

Recommendations

The Board is asked to **receive** the Chair's Report.

Previously Considered By:

N/A

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:**
Sharon Katema, Associate Director of Corporate Governance	Neil Masom, Trust Chair

Southport and Ormskirk Hospital NHS Trust

1. Feedback from North West Regional and Cheshire & Mersey Chairs Meetings

1.1 Chairs briefings have been given by the NHS Improvement, North West Regional Director and his team every fortnight during the pandemic. These have recently been complemented by monthly meetings across the Cheshire & Mersey Health Care Partnership (HCP). In addition, I have also attended a direct briefing from Sir Simon Stevens, NHS Chief Executive and his team.

1.2 The last briefing on 18 August focussed on:

a) Local outbreak management within the Northwest where 13 of the top 20 national 'hotspots' can be found, although none in the list are from Cheshire & Mersey (C&M).
b) Financial planning for the rest of the 2020/21 Financial year and the importance of incentivisation to achieve restoration of non-Covid-19 services by October.

2. 'System by Default'

a) Better decision making
b) Collaboration vs Competition
c) Better at tackling health inequalities
d) Productivity advances

3. Personal Activity in the Trust

3.1 In general since the last board meeting in July I have worked remotely from the Trusts but the following visits have occurred/are planned:

a) Maternity
b) Paediatrics

4. Charitable Funds

4.1 Significant increase in Charitable donations to the Trust which has fortunately been augmented by the appointment of Ashley Flint to the position of Fundraising Manager and is leading to a restructuring of the way we govern our Charitable Funds, with Executive Lead being now taken by the Associate Director of Corporate Governance and non-executive sponsorship from Julie Gorry; and a new subcommittee being established to focus on the two topics of

a) Raising Funds
b) Effective use of Funds

4.2 Notable significant contributions to the Charity have included, from

a) NHS Charities Together
b) Southport Rugby Club

5. Acute Sustainability Strategy

5.1 The programme board for this was suspended during the pandemic although informal engagement has continued. The programme was formally relaunched on 20 August

2020 and has been rebranded as the 'Shaping Care Together' Programme recognising the integrated cross system nature of the challenge. This board reports into the Commissioner led 'Joint Committee' covering Sefton and West Lancs.

6. Trust AGM

6.1 This will be held virtually on Wednesday 16 September from 10am till 12noon.

7. In Closing

7.1 Thanks and best wishes to Therese Patten as she leaves to her new role

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 September 2020**
Agenda Item	**TB128 /20**	**FOI Exempt**	**No**
Report Title	**Chief Executive Officer's 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 the Board of Directors with some high level updates since last Board meeting in July 2020.

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

Southport and Ormskirk Hospital NHS Trust

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 Nursing Times nomination

The intensive care team at Southport hospital has been shortlisted for a Nursing Times award in the emergency and critical care category. The team's submission focussed on the innovative ways staff worked during the peak of the Covid-19 pandemic to care for patients and meet the needs of their families. The winner of the award will be announced at an event in October.

1.2 Time to Shine Awards.

We will launch our annual 2020 Time to Shine Awards in September. As well as staff nominations, there will be the opportunity for local people to nominate in the People's Health Hero Awards. The awards will be presented in November.

1.3 Thanks a Bunch

We suspended our usual Thanks a Bunch Awards during the Covid-19 emergency in which staff nominate colleagues and teams for an award. We asked in the summer for staff to tell us who should be up for an award at their relaunch with an emphasis on colleagues who had gone the extra during the Covid. The first of 10 awards have been presented and presented to:

- Rose Fairclough and Jacqui Murphy – Ormskirk Stores
- Janette Mills – Head of Audit and Effectiveness

2. News and Developments

2.1 COVID-19 virus

Since the last Trust Board the NHS national incident status has moved from Level 4 to Level 3 which means the command and control structure remains in place but moves from a National to Regional level. Gold command meetings within the organisation have recently been reviewed and now take place on a weekly basis, however, a number of operational cells continue to meet on a daily basis. Our governance structures have been revised to reflect this.

The Trust recently received the phase 3 letter from NHSI setting out the expectations around recovery, performance, financial arrangements and winter planning. Trusts have been working to submit activity and workforce projections for the final two quarters of the financial year.

The Trust has also been successful in securing £1.7 million of capital funding to support winter planning. A further update on recovery and restoration plans will be presented further within the Trust Board agenda.

Over recent months we have been working hard to redesign our patient experience services with the aim to become much more proactive in engaging with our patients and their families. A key part of this work is to introduce a Patient Advice and Liaison Service (PALS). The launch of this is anticipated in the coming weeks and will be publicised both internally and externally.

3. Trust News

Southport and Ormskirk Hospital NHS Trust

3.1 Trust News

Appointments made since last Trust Board:

Steve Christian, Chief Operating Officer has been appointed as the Deputy Chief Executive following the departure of our current Deputy Chief Executive Therese Pattern who leaves us this week. I wanted offer my personal thanks to Therese for her contribution to the Trust over her time here. We wish her every success in her future role.

Mark Carmichael will be joining the Trust from the 1 September as the new Assistant Director of Operations for Urgent Care

4. NHSI/E/ Regulatory Meetings and Visits

4.1 Southport & Ormskirk Improvement Board

There have been no further meetings of the Southport and Ormskirk Improvement Board (SOIB) since the 4th June.

Following the Enforcement Notice schedule that was issued to the Trust in March 2020 a follow up visit from the Merseyside Fire and Rescue Service took place on the 19th August to review the Trusts Report and Action Plan. The meeting was productive and involved reviewing the five areas highlighted within the Enforcement Notice schedule. The Enforcing Authorities Officer was reassured with the Trust response, report and action plan and has advised us that she would seek further guidance and clarification on the various enforcement options available.

5. Reportable Issues Log

Issues occurring between 26/06/2020 to 24/08/2020

5.1 Serious Incidents and Never events

One STEiS reported

- Fall resulting in harm

5.2 Level Four and Five Complaints

Three reported.
Concerns were related to hospital discharge, care and treatment, DNAR and communication.
These are currently being investigated

5.3 Regulation 28 Reports

None to report. The Trust has been advised that Coroner's Inquest will resume again shortly remotely

5.4 Whistleblowing

No internal cases to report

6. Media Coverage

6.1 Money raised for NHS in memory of Southport rugby legend Graham (In Your Area, 30/07/20 and others) https://www.inyourarea.co.uk/news/nhs-money-raised-in-memory-of-southport-rugby-club-legend-graham/

6.2 Chaplains affirm duty to wear face coverings (Methodist Recorder 31/08/20 and others)

6.3 £1.7m funding tonic for NHS trust to upgrade A&E in time for winter (Champion newspapers, 10/08/20)

6.4 Midwife swims Mersey to raise money for hospital's Maternity Bereavement Fund (Granada News, 11/08/20 and others) https://www.itv.com/news/granada/2020-08-11/midwife-swims-mersey-to-raise-money-for-hospitals-maternity-bereavement-fund

6.5 Dementia and delirium team take 850,000 Step Challenge (Champion newspapers, 10/08/20)

6.6 Nurses climb Snowdon to fund children's smiles (OTS News, 24/8/20 and others) https://www.otsnews.co.uk/nurses-climb-snowdon-to-fund-childrens-smiles/

7. Risk Register and Board Assurance Framework

The revised format of the BAF will be presented at October's Trust Board. The updated extreme risk report was presented at this month's Quality and Safety Meeting.

Trish Armstrong-Child
Chief Executive
Date 25/08/20

Alert, Advise, Assure (AAAs)
Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	27 JULY 2020
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- It is advised that increasing numbers of patients on non-admitted pathways with mental health needs, particularly in children, adolescents and adults under-45, are having a significant impact upon A&E and are the primary cause of breaches to the 4-hour standard.
- The committee received a Diagnostic position report for June 2020, which highlighted significant risks relating to the impact of COVID-19. These include capacity, workforce, sickness and absence, and the impact of both staff and patients shielding. This is likely to have a material impact upon the Trust's ability to meet diagnostic waiting time constitutional standards, which will have a secondary impact upon other services.

ADVISE

- The Trust is continuing to operate within a revised financial framework and expenditure within the first quarter has enabled the Trust to deliver a consistent break even position. Despite this it is acknowledged that the Trust still operates with an underlying deficit that needs to be urgently addressed. The committee has requested that the CIP Group reconsider potential short-term savings that could be achieved in-year.
- The phase 1 retrospective bid to NHSI/E for £1.06M COVID-19 related capital spend is likely to be approved, with a confirmed position due at the end of July. Decisions relating to Phase 2 funding for future COVID-19 related capital investment are anticipated in August, and will impact on schemes for ED, paediatric A&E, CMO alterations, IT, and diagnostics.
- FP&I Committee have agreed to commission a deep dive in to the topic 'use of benchmarking data and costing information to improve productivity'.
- The new Head of Facilities will be reviewing domestic staffing levels because early indications suggest there may be a need to significantly improve existing standards.

ASSURE

- An A&E performance report was received, which highlighted continual improvements exceeding those projected for this year. June's performance was the second consecutive month that the Trust has exceeded the 95% compliance target, which is the only time this has been achieved since 2015. There is opportunity to make sustained and substantial further improvements to performance through proposed changes to emergency referrals.
- The committee received a Cancer Performance Improvement Update, which illustrates how the Trust has been outperforming Trusts across the region in regards to the 62 day standard, demonstrating real time progress and an improving trajectory.
- A schedule to review the progress of previously approved business cases is being developed, and the order of prioritisation will account for the size and potential impact of the different cases, with those of strategic significance being reviewed first.

New Risks identified at the meeting: None identified
Review of the Risk Register: *No action taken*

Alert, Advise, Assure (AAAs)
Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	24 AUGUST 2020
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The committee received a presentation outlining changes to the financial framework from month 7 of this financial year, which will see us move to an activity led system. This will include an activity incentive scheme, linked to challenging activity restoration targets. The timescales for Trusts to prepare draft and final submissions to STPs is extremely challenging and, given the significance, it is recommended that an extraordinary FP&I committee is called in lined with submission dates, to provide a level of support and scrutiny of the budget proposals.
- The Trust is forecast to experience a material increase in the number RTT 52 week breaches over the next 6 months. There is a high volume of waiters currently at 21-26 weeks, a proportion of which will flow through and lead to 52 week breaches. Further work is required to understand the impact of COVID-19 on the future flow of GP referrals.

ADVISE

- Although currently there remains to be no requirement for the Trust to report on CIP, the new Interim Director of Finance is to begin chairing fortnightly CIP meetings to review the 2020-21 CIP programme, and opportunities for 2021-22. The outcome of the Phase 3 recovery budget allocations may require the Trust to promptly revisit and enact CIP action plans in-year.
- The Committee received a PLICs roll-out plan, which outlined the Trust's ability to begin tracking performance through PLICs in early 2021. It was disappointing to hear within the meeting that CBU engagement has not progressed as far as it should to develop robust data sets, and this is risk to the roll-out plan. The proposal to procure PLICs interrogator software will help to provide benchmarking information to assess performance, which the committee agreed would be a positive development.
- Proposed changes to the approval and review process for all business cases, will include consideration for the appropriate governance role that the different assurance committees will play, which will be reflected in a revised BDISC Terms of Reference. These proposals will be presented in full to FP&I in September.
- The committee received a comprehensive progress report on the IM&T strategy and its implementation. The completion timeline on several key projects has slipped due to a combination of factors, which include COVID-19 and the team restructuring. The committee has requested that the IM&T strategy returns to the FP&I agenda for a more detailed discussion in October, in order for the committee to gain assurance that appropriate measures are in place to support delivery.

ASSURE

- At the request of the committee, a report was received that illustrated a reconciliation of the changes made to the 2019-20 capital plan and the associated impact upon 2020-21. The committee received a revised 2020-21 capital plan and recommend this for approval by the Board.

New Risks identified at the meeting: The committee noted a new extreme risk in relation to Fragile Services. Whilst this risk reports to Quality and Safety Committee, FP&I committed noted the risk and the potential financial impact.
Review of the Risk Register:*No action taken*

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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 September 2020**
Agenda Item	**TB130/20**	**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.

Recommendation

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

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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- ✓ **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	Executive Management Team

Activity Summary – July 2020

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	July 2019	June 2020	July 2020	Trend
Overall Trust A&E attendances	10,890	7,428	8,251	▼
SDGH A&E Attendances	5,207	4,115	4,407	▼
ODGH A&E Attendances	2,448	1,083	1,211	▼
SDGH Full Admissions Actual	1,134	1,193	1,308	▲
Stranded Patients AVG	170	126	140	▼
Super Stranded Patients AVG	66	45	46	▼
MOFD Avg Patients Per Day	60	40	42	▼
DTOC Unconfirmed Avg Per Day	8	-	-	
GP Referrals (*Exc. 2WW*)	2,680	977	990	▼
2 Week Wait Referrals	922	847	887	▼
Elective Admissions	201	51	97	▼
Elective Patients Avg. Per Day	6	2	3	▼

Activity Summary – July 2020

Southport and Ormskirk Hospital NHS Trust

Indicator Name	July 2019	June 2020	July 2020	Trend
Elective Cancellations	31	9	20	▼
Day case Admissions	1,959	691	1,114	▼
Day Case Patients Avg. Per Day	63	23	36	▼
Day Case Cancellations	38	8	16	▼
Total Cancellations (EL & Day Case)	69	17	36	▼
Total Cancellations (On or after day of admission, non clinical reasons)	7	0	0	▼
Outpatients Seen	24,254	16,903	19,191	▼
Outpatients Avg. Per Day	782	563	619	▼
Outpatients Cancellations	4,756	5,281	5,024	▲
Theatre Cases	627	250	349	▼
General & Acute Beds Avg. Per Day	418	444	446	▲
Escalation Beds Avg. Per Day	3	0	0	▼
In Hospital Deaths	60	61	54	▼

Trust Board - Integrated Performance Report July 2020

Head of Information Summary

The Board IPR has 88 indicators reporting across the 4 areas of Quality, Operations, Finance and Workforce. With regards to assurance there are 17 failing, 3 passing and 68 inconsistently passing or failing their target. 31 indicators are showing positive variation in recent months, 20 negative variation and 37 not showing any significant variation.

For those indicators failing their assurance target most have been impacted to some degree by Covid, either directly or indirectly. In the Quality section these include the percentage of deaths screened and delivering same sex accommodation. However, actions are in place to increase resource for mortality screens and DSSA breaches have been 0 since March.

In operations A&E 4 hour performance and ambulance handovers < 15 minutes have greatly improved in the department with a drastic reduction in demand, however as activity begins to increase again compliance with targets is becoming more challenging. Within the acute wards TIA performance has seen 5 consecutive months with performance above the median which is a demonstrable step change improvement. Ormskirk bed occupancy has been low since April and work is ongoing to reconfigure services in preparation for winter with Covid which will see better use of the Ormskirk bed base. Theatre Utilisation at both sites remains constricted by IPC regulations for dealing with Covid so this will continue to perform below plan going forward.

In Finance Agency costs are a recurring issue, however the failure in assurance is driven by pre-Covid performance and of recent months this has been much improved in light of the revised contracting structure in the NHS at present.

There are some Workforce indicators which are failing their assurance targets, sickness levels have been impacted by Covid, in particular in April. All sickness indicators are now showing positive variation and a much improved position though. Medical and Nursing vacancies are also failing, with Medical vacancy rates in particular showing declining variation at present.

There are some indicators which are inconsistent in their assurance but whose current variation measure is an early indication of cause for concern. Specifically these are indicators in the Access section of Operations which were impacted by Covid in April and May but it is only now when the severity of this impact is being seen. These include the RTT 18 week performance, number of waiters waiting over 30 weeks, 42 weeks and 52 weeks. The Diagnostic performance is also as of concern as the Trust continues to deal with inflated waiting lists.

Notable positive indicators in the Quality section include Sepsis – timely identification, which has been 100% for 7 consecutive months. Never events have had 0 incidents for 14 months and Patient safety incidents have been below the average for the past 5 months.

In Maternity there have only been 3 instances in the past 2 years when 1:1 care has not been provided and there have been 0 complaints for 6 consecutive months.

The HSMR in the mortality section has been reducing since June 2018 when it was at a high of 120 (against a target of <100), latest position is 83.1. Although the SHMI was following a similar trajectory up until November 2019 it has now started to increase slightly and latest reported figure is 102.2. Following analysis through the mortality operational group the identified cause of this is an increase in out of hospital deaths which have increased to more than 60% of all SHMI attributable deaths in Q4 of 2019/20. HSMR remains low as this just relates to a specific set of acute deaths.

The average turnaround time for complaints in Patient Experience has reduced consistently from approximately 100 days to 27 days in the latest month and has been lower than the target for the first time in the last 2 months.

In Operations, although the overall waiting list has reduced greatly in recent months this is anticipated to begin rapid growth as referrals start to increase again, especially in Joint Health which are high volume. Cancer 14 day performance has increased for the third consecutive month and at 99.3% is the highest monthly performance since the earliest measure in June 2018. Within Productivity indicators related to patient flow – MOFD and stranded patient metrics – were much improved during Covid however recent months are showing performance beginning to creep back up to pre-Covid levels as urgent care pathways activity levels continue to rise.

In Workforce the Time to Recruit now has 4 consecutive months below the average, and with a revised target of 55 days across all staff groups has been meeting this target for all of quarter 1 2020/21.

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Board Report

July 2020

NHS
Southport and Ormskirk Hospital
NHS Trust

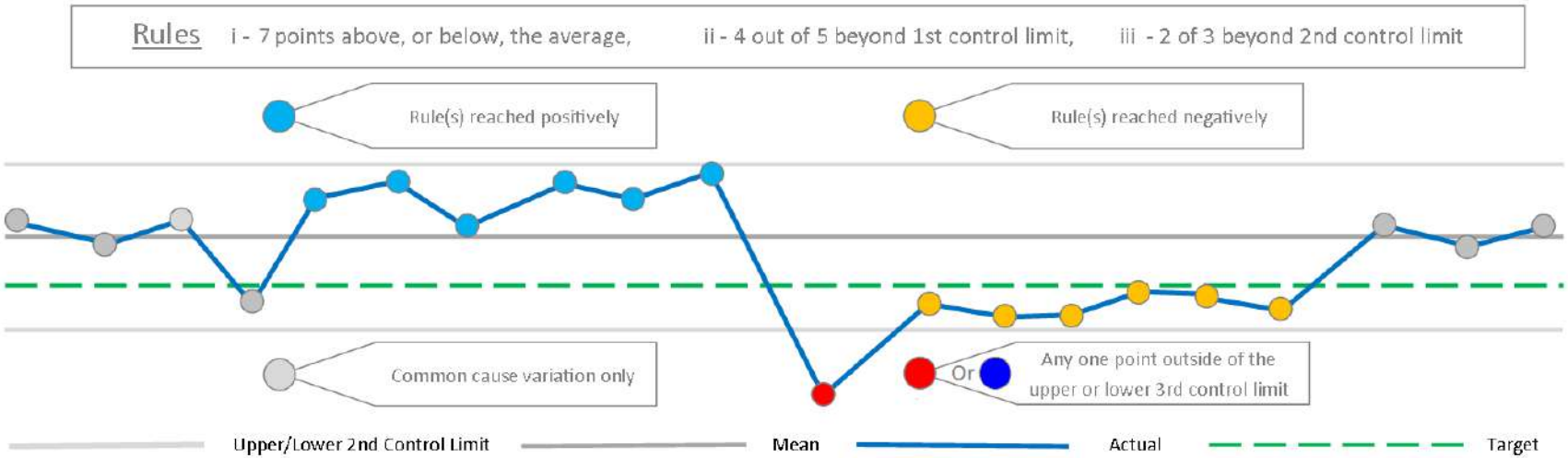
Guide to Statistical Process Control

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.



NHS Southport and Ormskirk Hospital NHS Trust

Executive Summary

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Harm Free	0	1	12	0	2	2	2	7
	Infection Prevention and Control	0	0	4	1	0	0	0	3
	Maternity	0	0	8	0	0	0	2	6
	Mortality	1	0	2	0	1	0	2	0
	Patient Experience	1	0	9	0	0	2	2	6
Operations	Access	3	0	10	4	1	2	3	3
	Cancer	0	0	3	0	0	1	0	2
	Productivity	3	1	6	1	2	0	5	2
Finance	Finance	2	0	8	0	1	2	4	3
Workforce	Agency	1	0	0	1	0	0	0	0
	Organisational Development	1	0	1	0	1	1	0	0
	Sickness, Vacancy and Turnover	5	1	5	5	0	0	1	5

Assurance

Measures the likelyhood of targets being met for this indicator.

	Indicates that this indicator is inconsistently passing and falling short of the target.
	Indicates that this indicator is consistently passing the target.
	Indicates that this indicator is consistently falling short of the target.

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

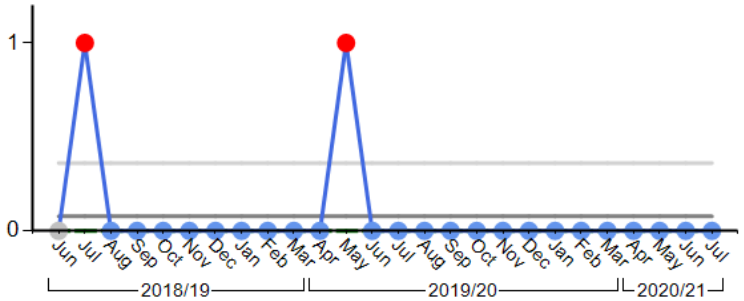
Harm Free

Analyst Narrative: Safe Staffing has reached the highest level for nearly 12 months following a challenging period over winter and then Covid.

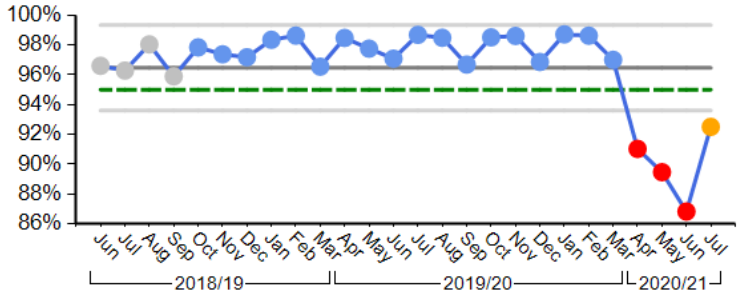
Operational Narrative: VTE – 2 low reporting areas accounting for deterioration in position. Impact of COVID re-configuration on eligible areas has been part contributory to drop in performance. Recovery plan in place
CHPPD and Safe Staffing Variance – CHPPD is reducing following work on roster templates as a result of COIVD and reconfiguration changes. Staffing fill-rate is on an upwards trajectory
Pressure Ulcers : 6 reported. Two were deemed unpreventable with no lapses in care, one identified lapses in care due to mechanical error. The remaining 2 have not yet been presented at HFCP. The DTI has been StEIS reported.
Incident reporting – 12% increase in July which was predicted in June and is well above the mean for the financial year.
NOF performance remains challenged due the theatre availability

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Jul 20	L	0	0	Jun 20	0	0	?
VTE Prophylaxis Assessments	95%	92.5%	257	Jul 20	L	95%	86.8%	Jun 20	95%	90%	?
Falls - Moderate/Severe/Death	0	1	1	Jul 20		0	0	Jun 20	0	4	?
Patient Safety Incidents - Low, Near Miss or No Harm	822	708	708	Jul 20	L	822	620	Jun 20	822	2265	?
Safe Staffing	95%	93.3%	N/A	Jul 20	L	95%	90%	Jun 20	95%	88.5%	?
Fractured Neck of Femur	90%	77.4%	24	Jul 20		90%	73.9%	Jun 20	90%	66.3%	?
Hospital Pressure Ulcers - Grade 2	1	5	N/A	Jul 20		1	6	Jun 20	18	23	?
Hospital Pressure Ulcers - Grades 3 & 4	1	1	1	Jul 20		1	2	Jun 20	1	5	?
WHO Checklist	99.9%	100%	0	Jul 20		99.9%	100%	Jun 20	99.9%	100%	?
Sepsis - Timely Identification	75%	100%	N/A	May 20	H	75%	100%	Apr 20	75%	100%	P
Sepsis - Timely Treatment	75%	91.7%	N/A	May 20		75%	62.5%	Apr 20	75%	80%	?
Care Hours Per Patient Day (CHPPD)	7.9	10.4	N/A	Jul 20	H	7.9	11.1	Jun 20	7.9	11.2	?

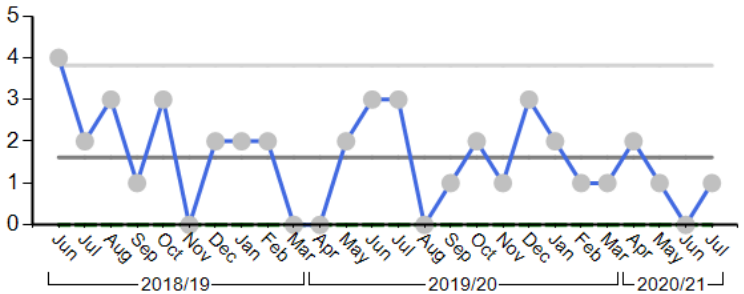
Never Events



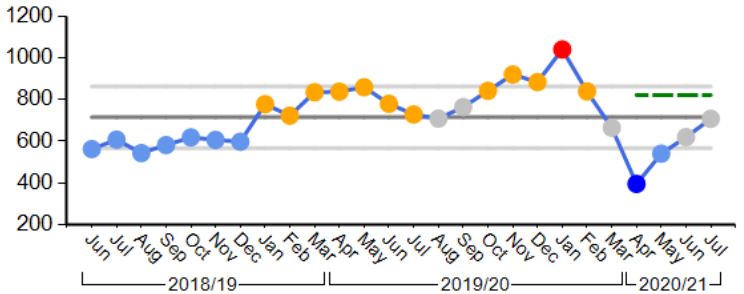
VTE Prophylaxis Assessments



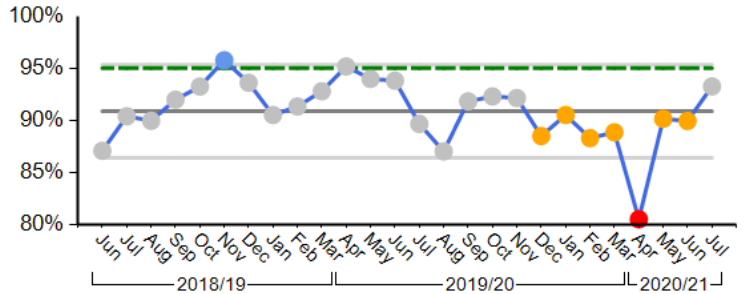
Falls - Moderate/Severe/Death



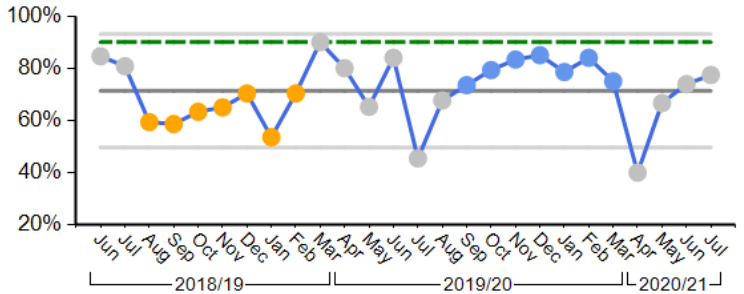
Patient Safety Incidents - Low, Near Miss or No Harm



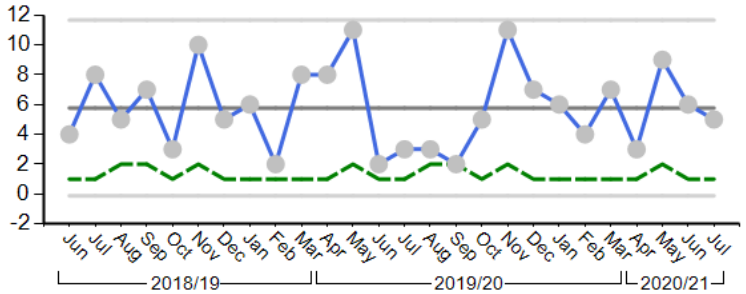
Safe Staffing



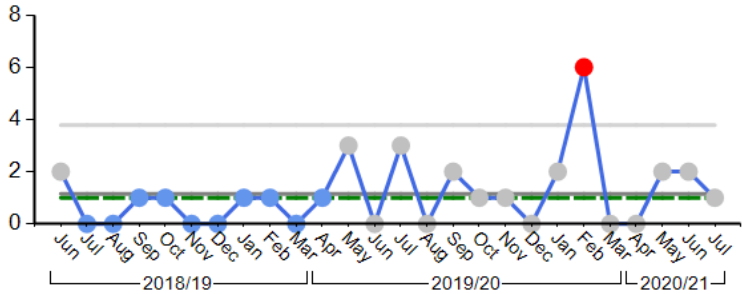
Fractured Neck of Femur



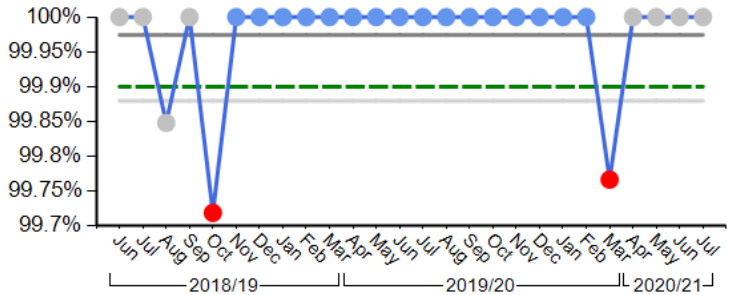
Hospital Pressure Ulcers - Grade 2



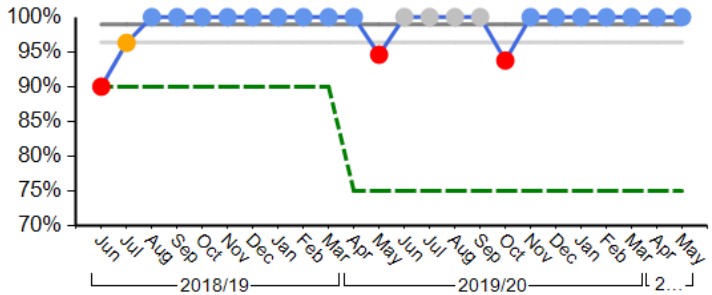
Hospital Pressure Ulcers - Grades 3 & 4



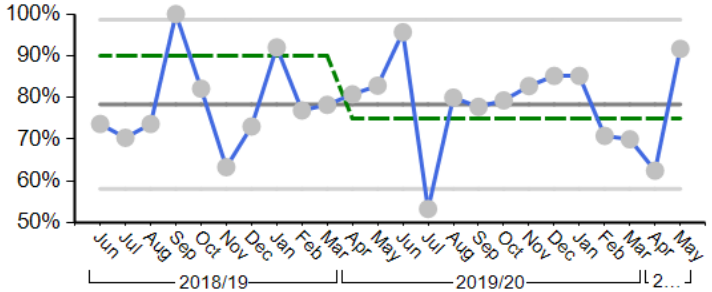
WHO Checklist



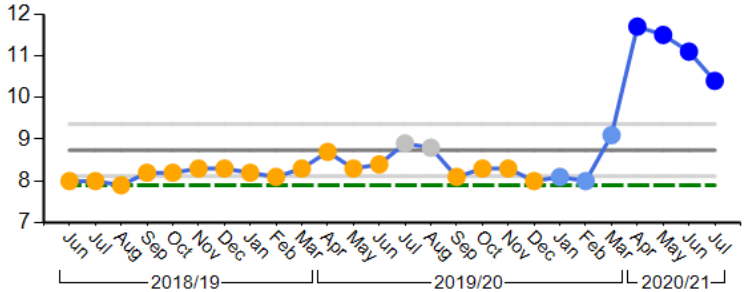
Sepsis - Timely Identification

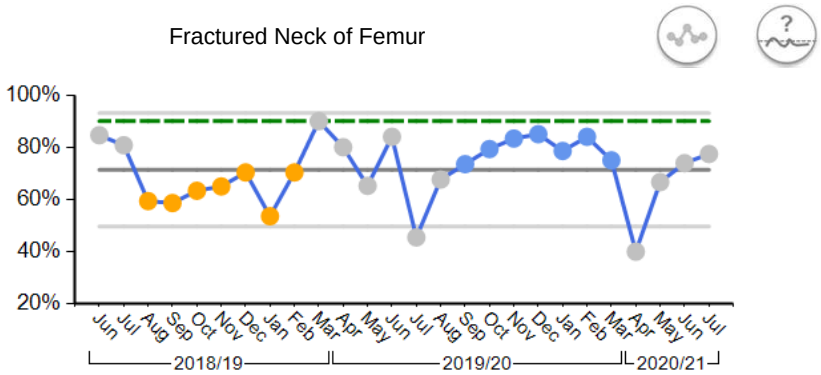


Sepsis - Timely Treatment



Care Hours Per Patient Day (CHPPD)




Fractured Neck of Femur
100%
80%
60%
40%
20%
Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
2018/19
2019/20
2020/21

Quality

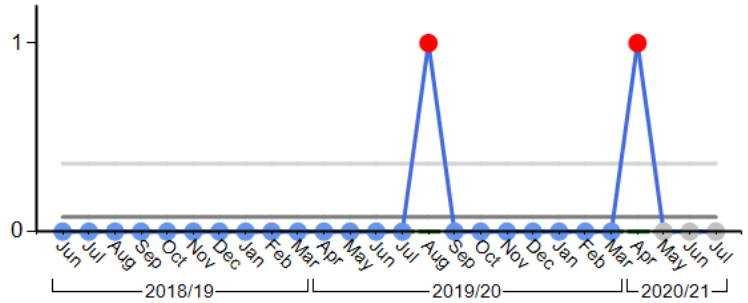
Infection Prevention and Control

Analyst Narrative: All IPC indicators are performing within statistically expected limits with no significant variation

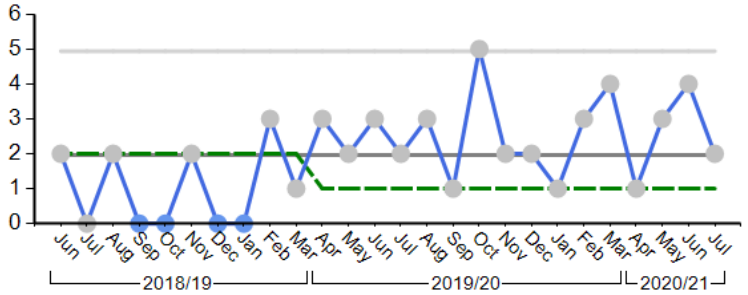
Operational Narrative: E coli - 2 hospital acquired E coli bacteraemia in July. No lapses in care identified.
Clostridium difficile - 2 C diff cases in July. No lapse in care.
Note 10 C diff cases this year from April, 6 no lapses in care identified so will be sent for appeal.
The Trust is over trajectory for C diff as the objective is to have no more than 16 in the year, however we need to take into consideration no lapses in care.
Infection control panels in month chaired by the DIPC will be critical in 2020/21 to provide ongoing assurance

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Jul 20		0	0	Jun 20	0	1	
C-Diff	1	2	2	Jul 20		1	4	Jun 20	15	10	
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	10	N/A	Jul 20	H	6.9	9.9	Jun 20			
E. Coli	2	2	2	Jul 20		2	0	Jun 20	2	6	

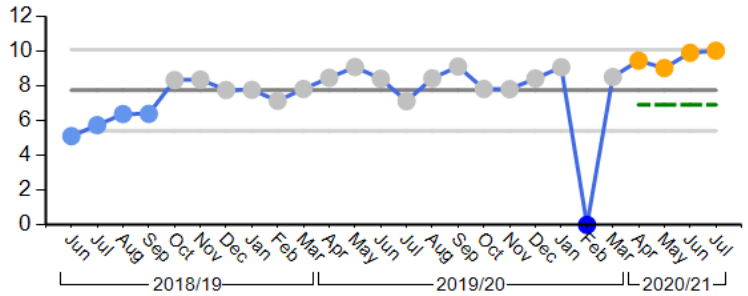
MRSA



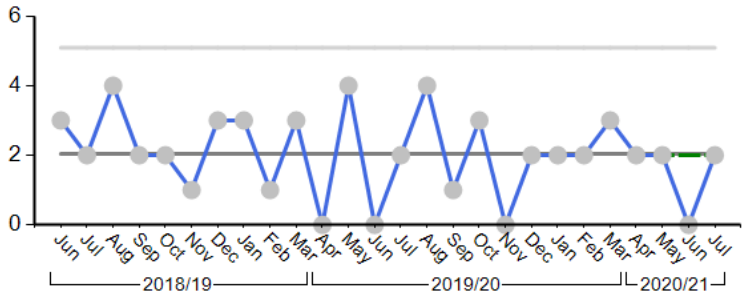
C-Diff



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



E. Coli



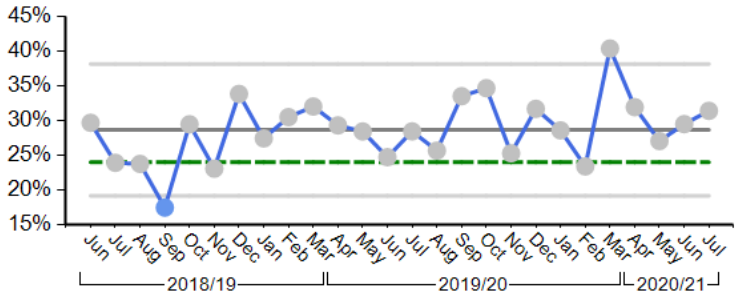
Quality

Maternity

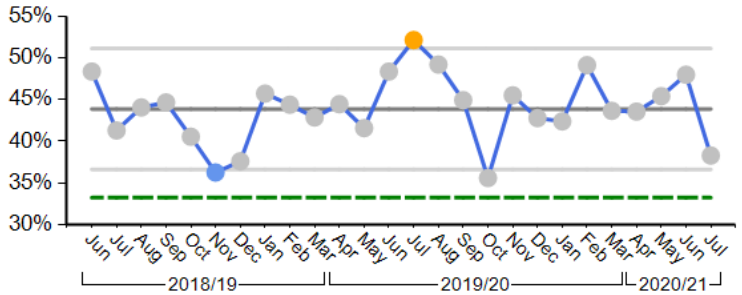
Operational Narrative: Statistically metrics remain static in Maternity with exeption of complaints reduction and 1-1 care
C section rates – currently being monitored through PIDA board. CBU currently reviewing performance and due to present evaluation next month
Induction rates – reduction in month. Monitored though PIDA for trend change

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Caesarean Rates	24%	31.4%	59	Jul 20		24%	29.5%	Jun 20	24%	29.9%	
Induction Rate	33.3%	38.3%	72	Jul 20		33.3%	48%	Jun 20	33.3%	43.8%	
Breastfeeding Initiation	60%	54%	86	Jul 20		60%	56.3%	Jun 20	60%	60.3%	
Percentage of Women Booked by 12 weeks 6 days	90%	96.5%	6	Jul 20		90%	91.2%	Jun 20	90%		
Number of Occasions 1:1 Care Not Provided			0	Jul 20				Jun 20			
Percentage of 3rd/4th Degree Tears	0	0	0	Jul 20		0	4	Jun 20	0	6	
Number of Maternal Deaths	0	0	0	Jul 20		0	0	Jun 20	0	0	
Number of Maternity Complaints	0	0	0	Jul 20		0	0	Jun 20	0	0	

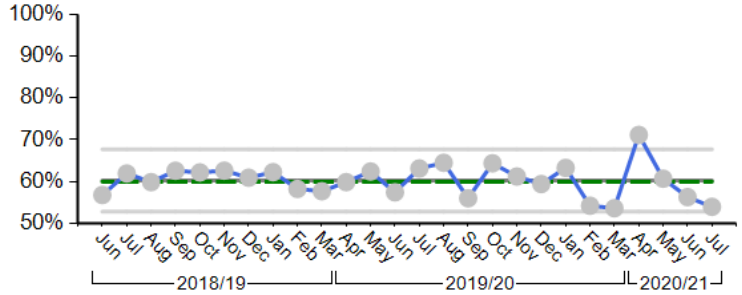
Caesarean Rates



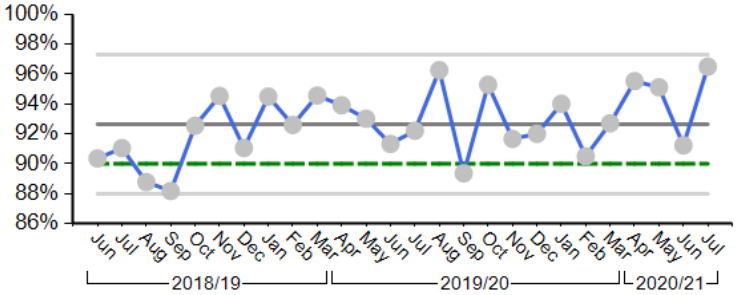
Induction Rate



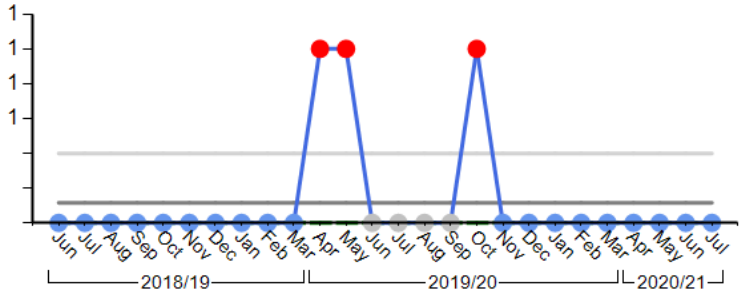
Breastfeeding Initiation



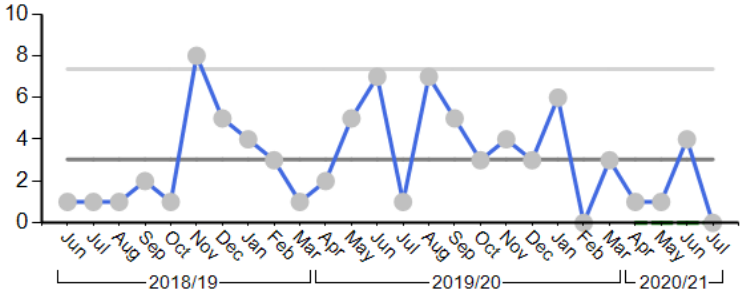
Percentage of Women Booked by 12 weeks 6 days



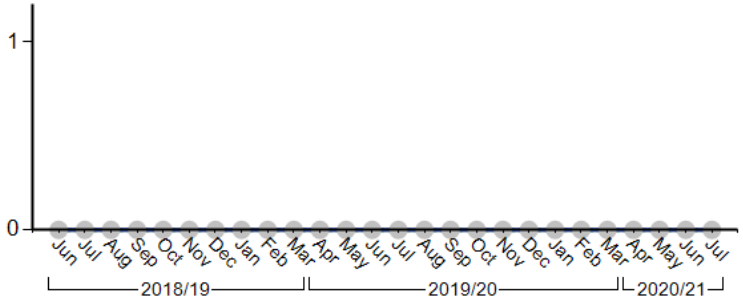
Number of Occasions 1:1 Care Not Provided



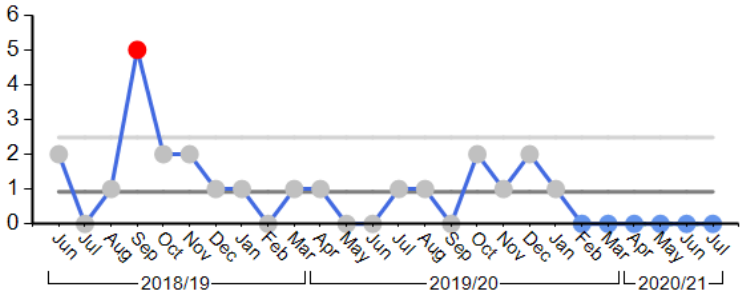
Percentage of 3rd/4th Degree Tears



Number of Maternal Deaths



Number of Maternity Complaints



Quality

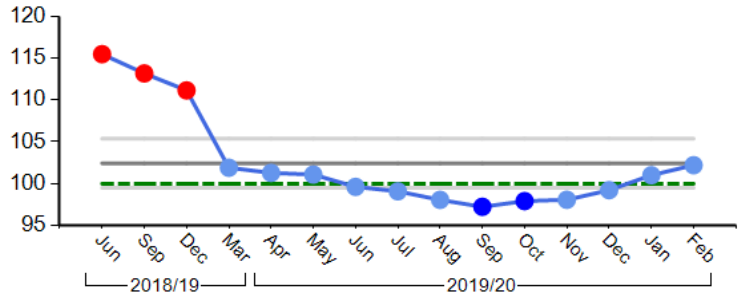
Mortality

Analyst Narrative: Both HSMR and SHMI have been impressive improvements over the past 2 years however, SHMI is beginning to decline with 5 consecutive months of increase. Percentage of deaths screened is at an all-time low following significant improvement made in the summer of 2019.

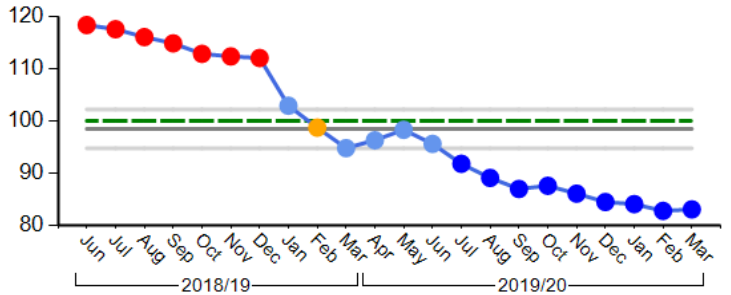
Operational Narrative: Screening deaths. Going forward from September we will have a Medical examiner role in operation which will deliver 100 % screening rates.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	102.2	N/A	Feb 20		100	101	Jan 20	100	99.5	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	83.1	N/A	Mar 20		100	82.8	Feb 20	100	83.1	
Percentage of Deaths Screened	100%	14.8%	52	Jun 20		100%	28.3%	May 20	100%	19%	

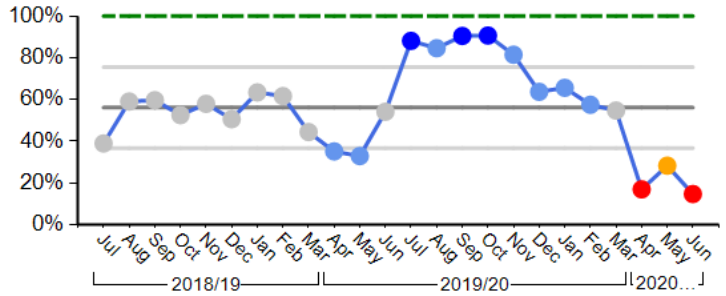
SHMI (Summary Hospital-level Mortality Indicator)



HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Quality

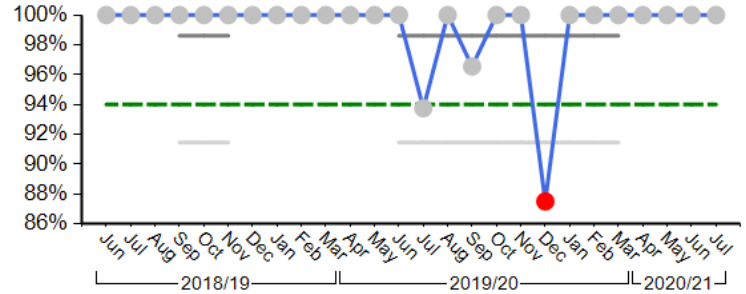
Patient Experience

Analyst Narrative: Most notable indicators in this section are Compliments which have been below average for 8 months now and Complaints average turnaround time which has reduced significantly over the 15 month period measured.

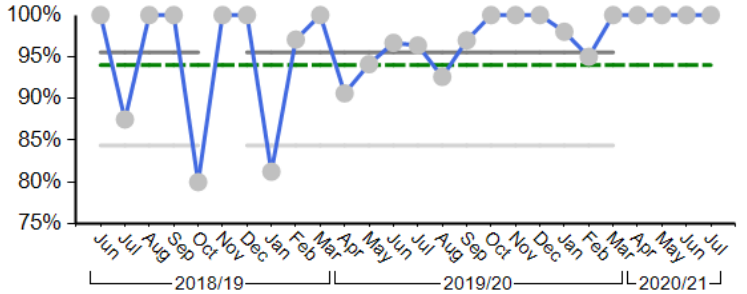
Operational Narrative: Complaints – improved position maintained in line with expected trajectory reduction
Compliments – improvement plans to be presented by each CBU at PIDA board August
Duty of Candour – positive position maintained
FFT – data not available for metrics on return rate. This will be available for next month

	Latest					Previous			Year to Date		
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	H	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	1	1	Jul 20		0	9	Mar 20	0	1	F
Written Complaints	35	24	24	Jul 20	L	35	16	Jun 20	537	56	
Complaints Average Turnaround Time	40	27	N/A	Jul 20	L	40	31	Jun 20	40	161	
Duty of Candour - Evidence of Discussion	100%	100%	0	Jun 20	H	100%	100%	May 20	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	Jun 20		100%	85.7%	May 20	100%	95.2%	
Friends and Family Test - Staff - % That Would Recommend - Trust Overall		65.3%	124	Sep 19			69.2%	Jun 19		66%	

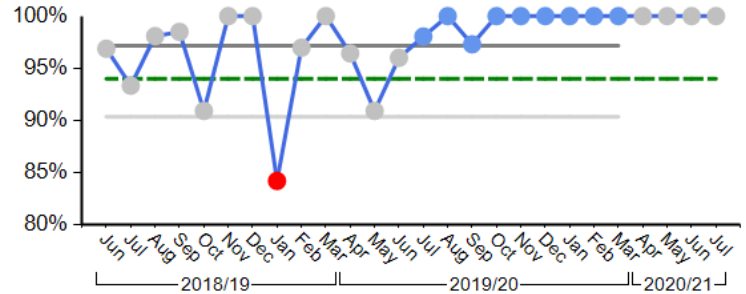
Friends & Family - % That Would Recommend - AnteNatal Community



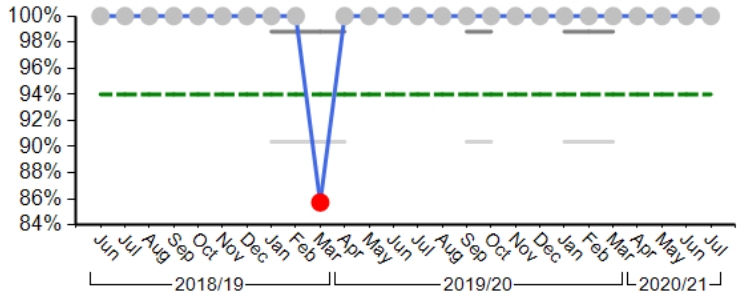
Friends & Family - % That Would Recommend - Labour Ward



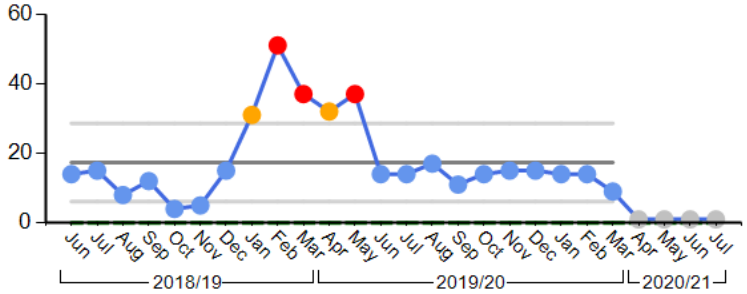
Friends & Family - % That Would Recommend - Post Natal Ward



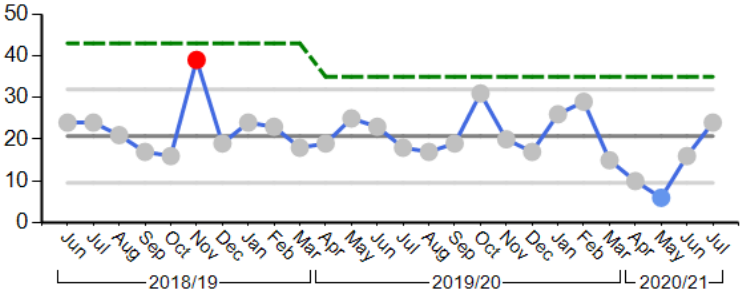
Friends & Family - % That Would Recommend - Post Natal Community



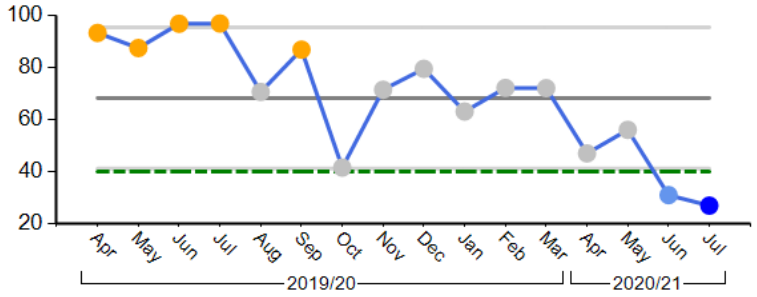
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



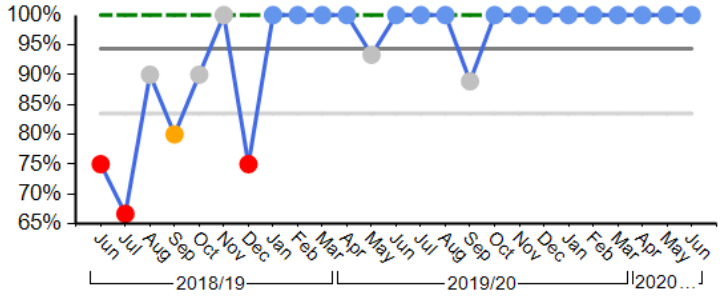
Written Complaints



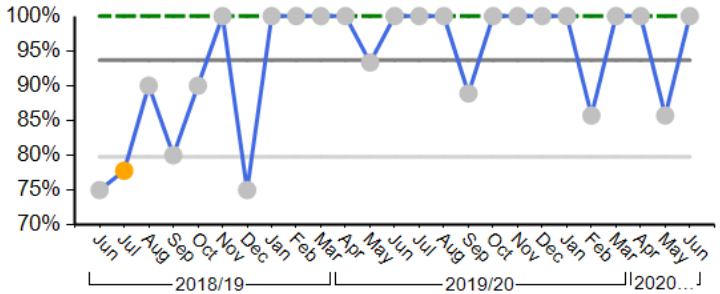
Complaints Average Turnaround Time



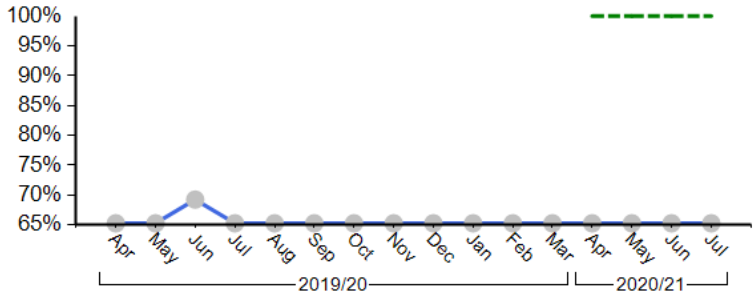
Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



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



Operations

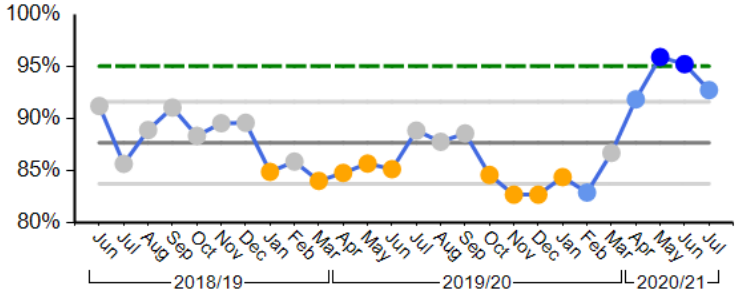
Access

Analyst Narrative: A&E 4 hour compliance recovered significantly during April, May and June as less patients attended A&E however in recent months there have been 2 consecutive drops in performance. The dramatic decrease in Diagnostic Waits has been turned around and is due to hit the average of 10% within the next 2 months. Referral to Treatment Ongoing performance is still declining but less quickly than previous months. A driver for the low percentage is the comparitively low number of pathways due to a decrease in the number of referrals received.

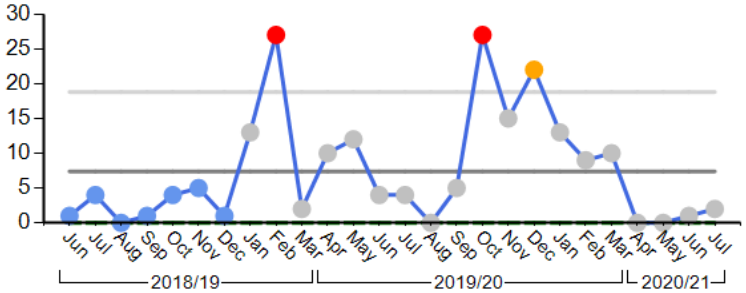
Operational Narrative: 4 Hour Compliance: July has seen a decrease in performance compared with the previous month and against the YTD actual. The Trust is starting to see the return of pre-covid attendances in ED. Work continues with system partners (Primary Care and Community) to improve quality of referrals, streaming and deflection to decrease patient attendance. This work will take time to implement.
Due to Covid pressures Diagnostic performance has deteriorated significantly however July performance is showing a continued improvement that was seen in June. Work to improve this measure continues however a significant proportion of this relies on the move of MDU out of the Treatment Centre which is expected in October. There has been a continued drop in RTT performance however the drop has been less marked than previous months. Restrictions are still in place due to Royal College guidance. Long waiters (>30 wks, >42 wks, 52 week waits continue to increase).
A number of actions are underway:
• Work continues to increase utilisation of Outpatients and Theatres;
• Deferred referrals are being actively booked into clinic.
• Work continues in getting long waiters in for treatments however still seeing impact of patient treatment choice around covid and self-isolation requirements.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	92.7%	601	Jul 20		95%	95.2%	Jun 20	95%	94%	
Accident & Emergency - 12+ Hour trolley waits	0	2	2	Jul 20		0	1	Jun 20	0	3	
Ambulance Handover 30-60 Mins	0	10	10	Jul 20		0	14	Jun 20	0	58	
Ambulance Handover Over 60 Mins	0	0	0	Jul 20		0	3	Jun 20	0	3	
Referral to treatment: on-going	92%	57.6%	2740	Jul 20		92%	60.1%	Jun 20	92%	68.9%	
52 Week Waits	0	12	12	Jul 20		0	7	Jun 20	0	7	
Diagnostic waits	1%	30.2%	817	Jul 20		1%	49.8%	Jun 20	1%	46.7%	
Stroke - 90% Stay on Stroke Ward	80%	65.8%	13	Jul 20		80%	86.4%	Jun 20	80%	73.4%	
TIA	60%	100%	0	Jul 20		60%	66.7%	Jun 20	60%	66.7%	
Cancelled Operations	0.6%	0%	0	Jul 20		0.6%	0%	Jun 20	0.6%	0%	
Total RTT Waiting List - Trust		6465	6465	Jul 20			6142	Jun 20		6465	
Total RTT waiters > 30 Weeks - Trust		727	727	Jul 20			602	Jun 20		727	
Total RTT waiters > 42 Weeks - Trust		134	134	Jul 20			48	Jun 20		134	

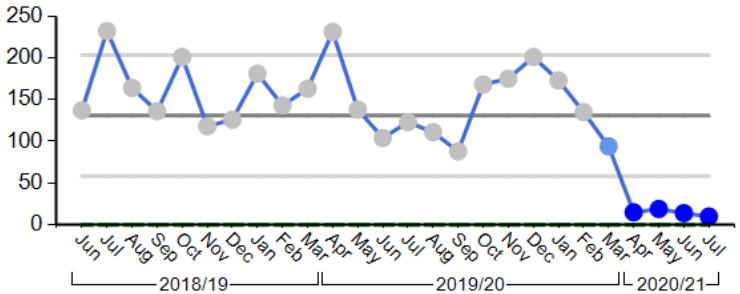
Accident & Emergency - 4 Hour compliance



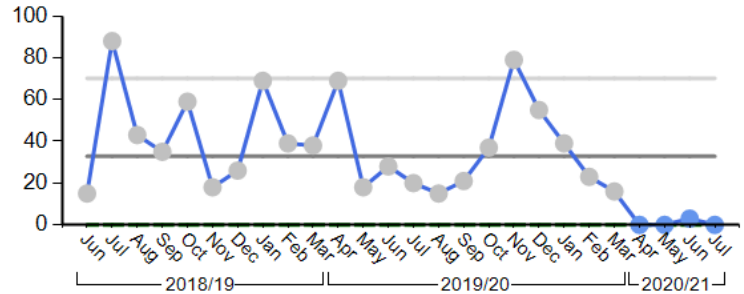
Accident & Emergency - 12+ Hour trolley waits



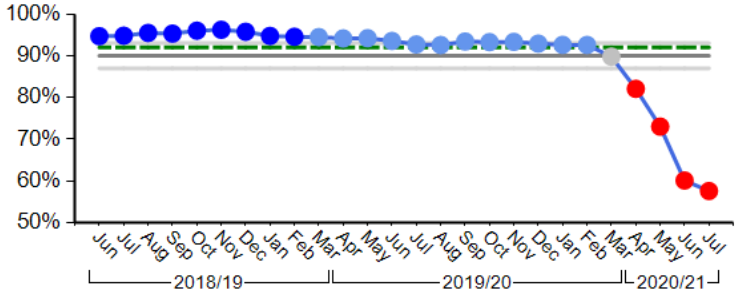
Ambulance Handover 30-60 Mins



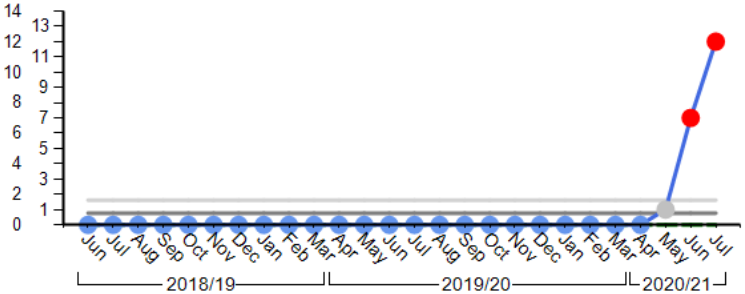
Ambulance Handover Over 60 Mins



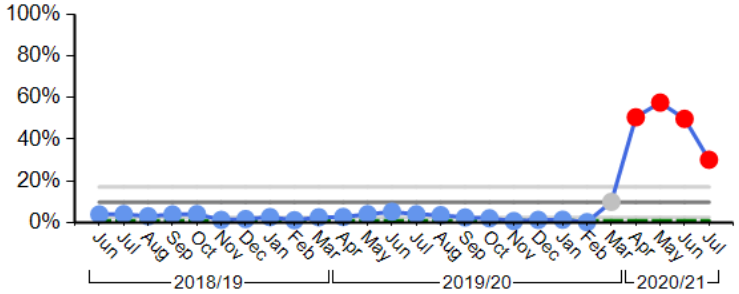
Referral to treatment: on-going



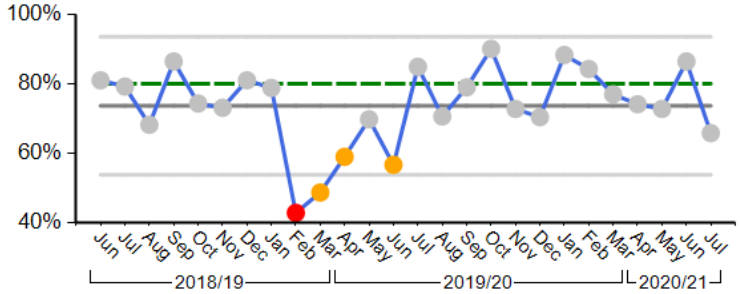
52 Week Waits



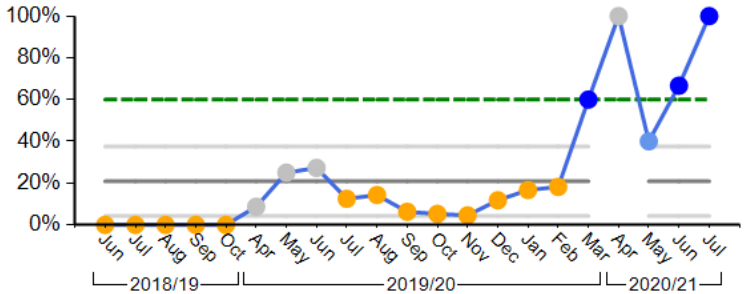
Diagnostic waits



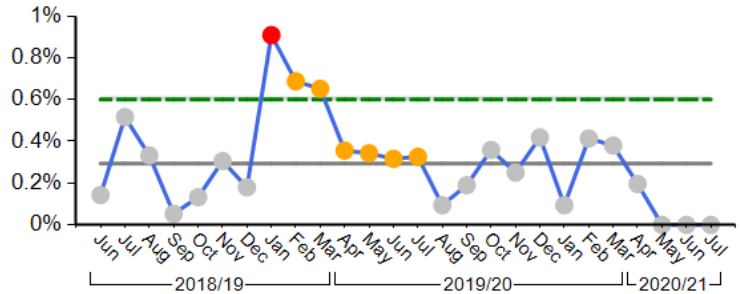
Stroke - 90% Stay on Stroke Ward



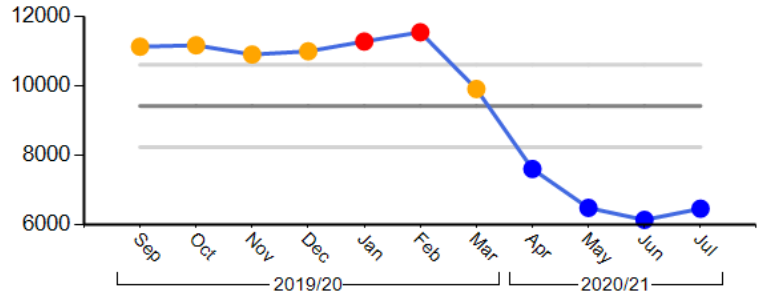
TIA



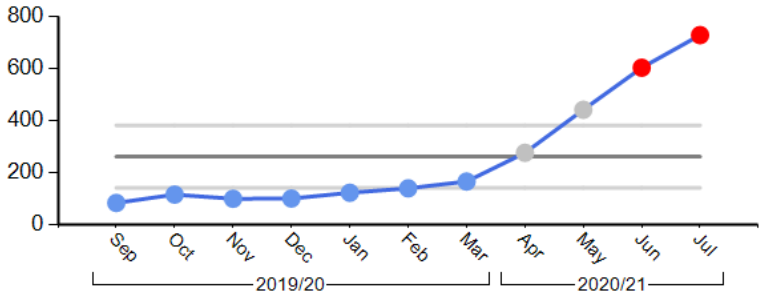
Cancelled Operations

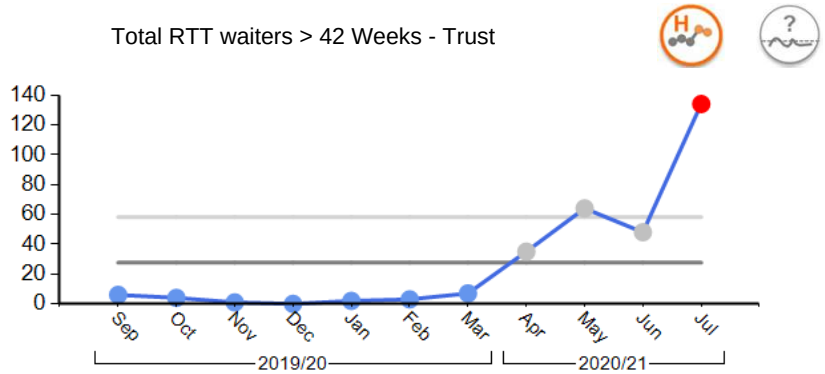


Total RTT Waiting List - Trust



Total RTT waiters > 30 Weeks - Trust




Total RTT waiters > 42 Weeks - Trust
140
120
100
80
60
40
20
0
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
2019/20
2020/21

Operations

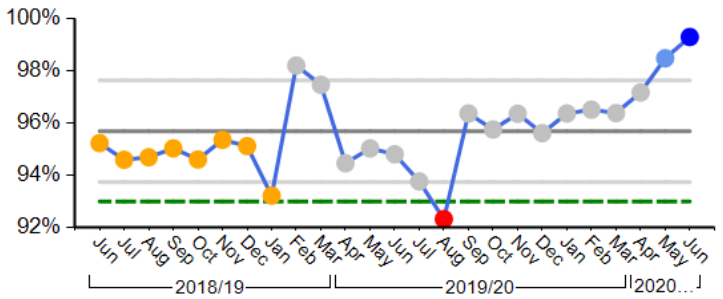
Cancer

Analyst Narrative: 14 day GP referral to Outpatients performance continues to improve, seeing the best performance in the past 2 years at 99.3%.

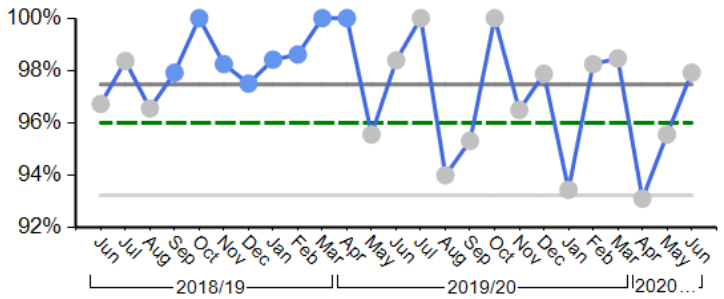
Operational Narrative: 14 Day GP Referral to OP - Improved performance to 99.3%.
31 Day Treatment - Improved performance to 97.9%
62 Day GP RTT - Decrease in performance to 74.6%
Some extremely pleasing results given the pressures of covid. Work continues on all cancer groups. Patients choice in regards deferral of treatment continues to impact performance for some cancer groups. Pressure will increase on services as referrals start to increase.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	99.3%	5	Jun 20		93%	98.5%	May 20	93%	98.6%	
31 day treatment	96%	97.9%	1	Jun 20		96%	95.6%	May 20	96%	95.4%	
62 day GP referral to treatment	85%	74.6%	8.5	Jun 20		85%	93.8%	May 20	85%	78.4%	

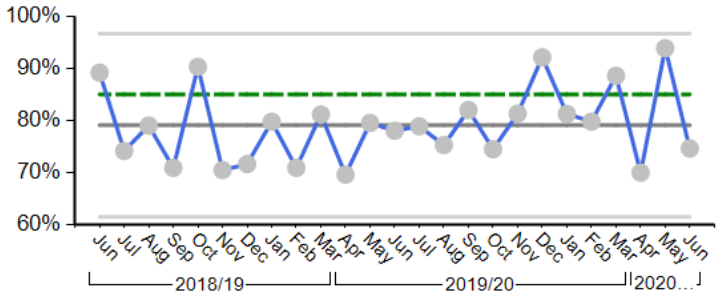
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment



Operations

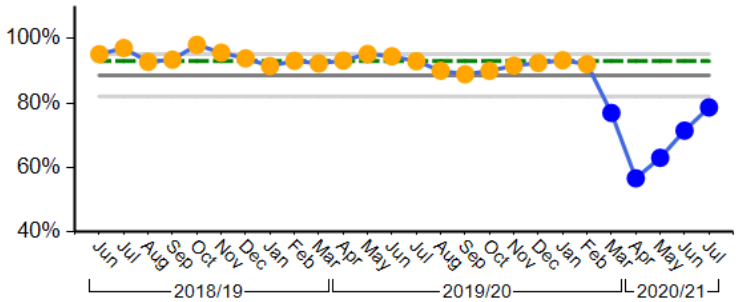
Productivity

Analyst Narrative: Ambulance handovers are showing a vast improvement recently although not enough to get close to the challenging 100% target. Bed Occupancy at Southport is starting to return to normal range after a large drop due to Covid. Ormskirk occupancy is also recovering but at a slower rate. Many indicators such as Southport Bed Occupancy, MOFD, DNA Rate, Ormskirk Theatre Utilisation and Stranded show a similar trend of a significant improvment in April followed by a slow return towards normal levels which is likely to continue for at least the next couple of months. Southport A&E Conversion Rate is a particular concern, especially as Bed Occupancy at Southport is quickly returning to pre-Covid levels meaning that without intervention, waiting times in A&E could increase for patients waiting for admission.

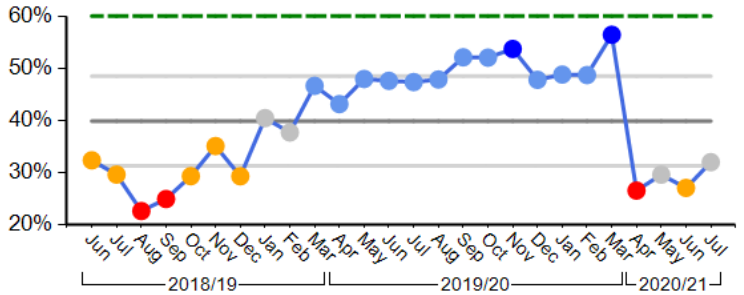
Operational Narrative: OP Slot Utilisation - Continues to see a month on month improvement as clinics are recommenced – combinations of face to face, telephone and digital are offered to patients depending on consultant recommendations and patient choice.
Stranded Patients - Number of patients has increased compared with June however it is noted that super stranded has not had the same increase. Work with system partners around discharge is ongoing as preparations continue for a winter with covid.
Bed Occupancy – SDGH and ODGH - Occupancy at Southport continues to increase month on month – the work with system partners will become crucial in ensuring patient flow as the Trust enters the winter period. Occupancy at ODGH remains low however has increased slightly as more theatre sessions have been added. This occupancy is expected to increase further as the Trust enters Phase III of the Covid recovery and work continues on improving ODGH theatre utilisation.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Bed Occupancy - SDGH	93%	78.6%	N/A	Jul 20		93%	71.4%	Jun 20	93%	67.5%	
Bed Occupancy - ODGH	60%	32%	N/A	Jul 20		60%	27.1%	Jun 20	60%	28.8%	
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	42	42	Jul 20		50	40	Jun 20	50	36	
Stranded Patients (>6 Days LOS)	170	140	140	Jul 20		170	126	Jun 20	170	493	
Super Stranded Patients (>20 Days LOS)	58	46	46	Jul 20		58	45	Jun 20	58	165	
New:Follow Up	2.63	2.6	N/A	Jul 20		2.6	2.1	Jun 20	2.6	2.5	
DNA (Did Not Attend) rate	8%	5.6%	1128	Jul 20		8%	5.1%	Jun 20	8%	5%	
Theatre Utilisation - SDGH	85%	54.7%	N/A	Jul 20		85%	50.8%	Jun 20	85%	52.8%	
Theatre Utilisation - ODGH	95%	46.6%	N/A	Jul 20		95%	41.9%	Jun 20	95%	43.1%	
Southport A&E Conversion Rate	28%	27.3%	1204	Jul 20		28%	26.3%	Jun 20	28%		

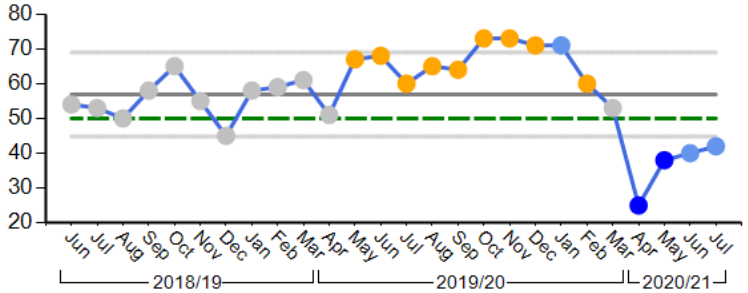
Bed Occupancy - SDGH



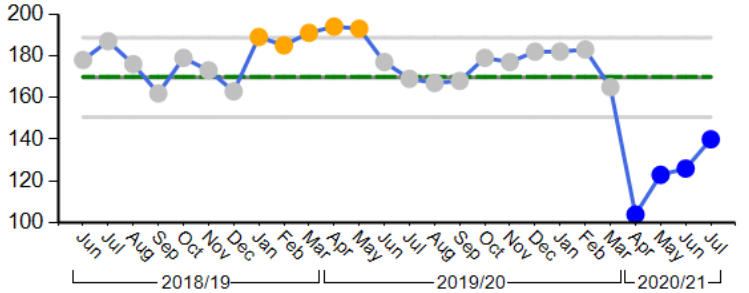
Bed Occupancy - ODGH



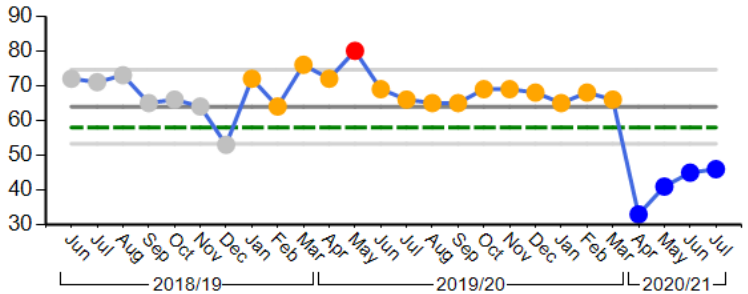
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month



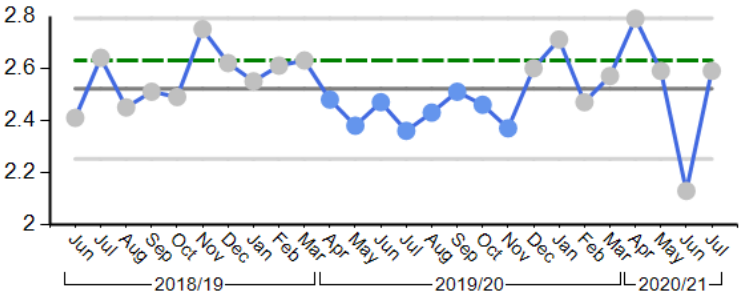
Stranded Patients (>6 Days LOS)



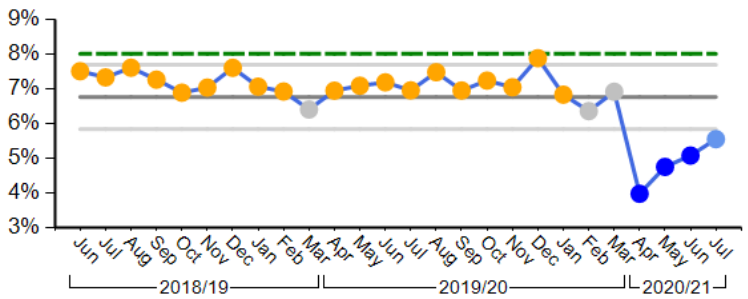
Super Stranded Patients (>20 Days LOS)



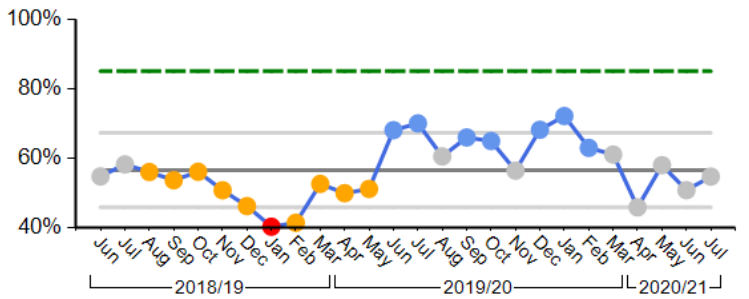
New:Follow Up



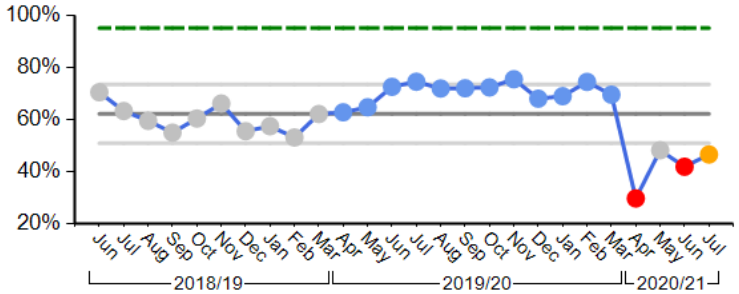
DNA (Did Not Attend) rate



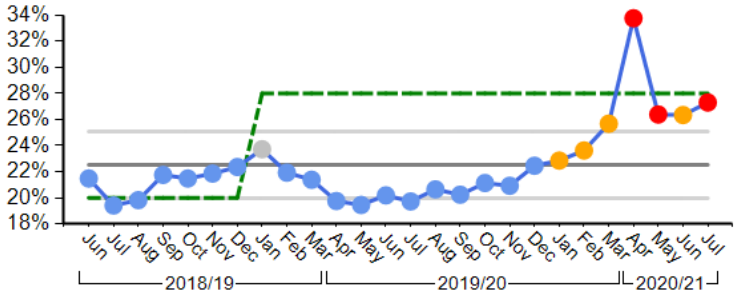
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate



Finance

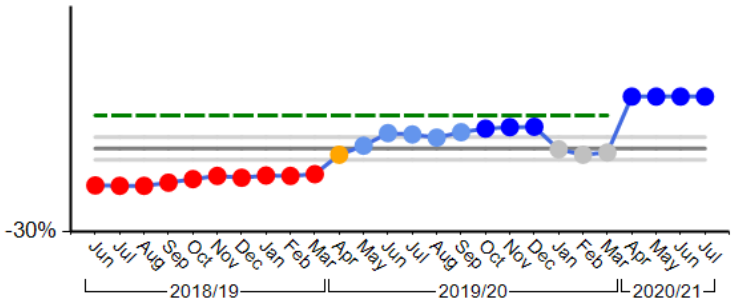
Finance

Operational Narrative: COVID-19 has led to the suspension of the 2020/21 Operational Planning process and a new financial framework introduced for the period 1st April to 31st July. This arrangement will now continue until September resulting in break even in the first six months of the financial year through monthly block contracts and “top up” funding. The I&E break-even plan for July has been achieved with, once again, a lower top up figure required although July financial performance required the highest monthly top up to date. The agency cost remains the same in July (8.4% of the paybill relates to agency staff).Pay run rate is lower than June but non pay has risen significantly in month (£670,000 increase on June) reflecting the impact of the restart of the elective programme.
Bank and agency spend – remained consistent in the last 2 months at £2 million which is associated with continued high level of vacancies even though there has been progress in recruiting into substantive nursing post. A product of the high vacancy level is that agency spend is consistently at circa 8% of the pay bill over the last five months which is at the top end of provider organisations.
Capital service capacity -there has been a step change in this metric from last year and this has been driven by the fact that the Trust is now in a breakeven position and has a positive EBITDA.
Liquidity -again there has been a step change in this metric as all our DHSC loans have been classified as current liabilities. DHSC are due to convert the loans into public dividend capital (PDC) in September and at that point the liquidity calculation will significantly improve. In practical terms though there are no cash flow issues as we are being paid in advance by our Commissioners and also receiving a monthly top up. The Trust’s liquidity situation may change after month 6 depending on the financial framework in place in the second half of the year.

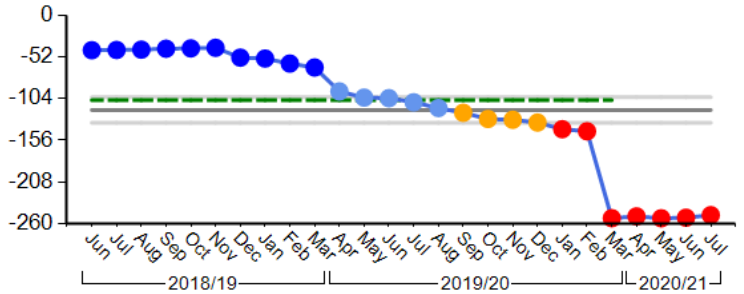
Use of Resources – currently a score of 2 but this reflects the current artificial break even position of all NHS organisations.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
I&E surplus or deficit/total revenue		0%	N/A	Jul 20	H	-4.2%	0%	Jun 20		0%	?
Liquidity		-249	N/A	Jul 20	L	-106	-252	Jun 20		-249	?
Distance from Control Total	0%	0%	N/A	Jul 20		0%	0%	Jun 20	0%	0%	?
Capital Service Capacity		4.76	N/A	Jul 20	H	0.2	4.58	Jun 20		4.76	?
% Agency Staff (cost)	5%	8.4%	N/A	Jul 20		5%	8.2%	Jun 20	5%	8.3%	F
Use of Resources (Finance) Score	3	2	N/A	Jul 20	L	3	2	Jun 20		3	?
Distance from Agency Spend Cap	0%	0%	N/A	Jul 20	L	0%	0%	Jun 20	0%	0%	F
Pay Run Rate - Trust		£11,984K	N/A	Jul 20			£11,899K	Jun 20		£48,031K	?
Non Pay Run Rate - Trust		£4,558K	N/A	Jul 20	L		£3,931K	Jun 20		£16,723K	?
Bank & Agency Run Rate - Trust		£1,721K	N/A	Jul 20	L		£1,529K	Jun 20		£6,590K	?

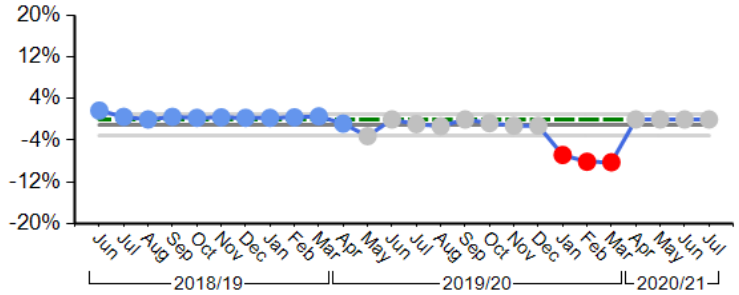
I&E surplus or deficit/total revenue



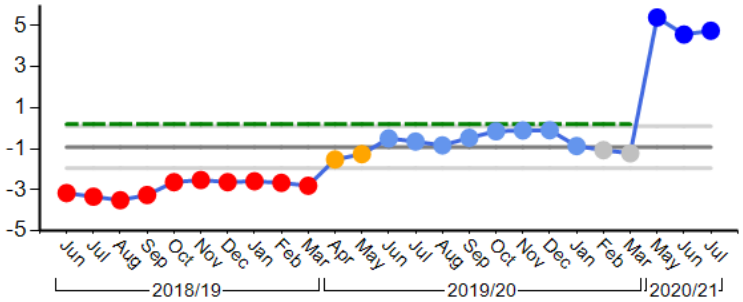
Liquidity



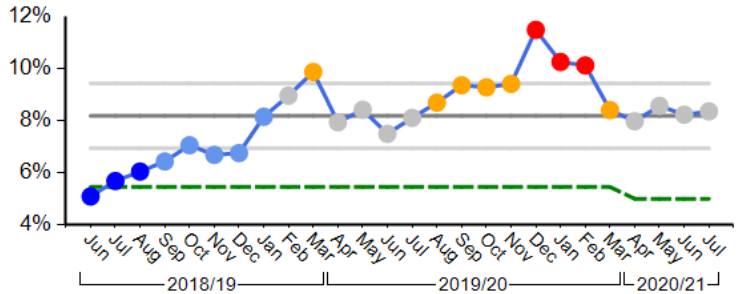
Distance from Control Total



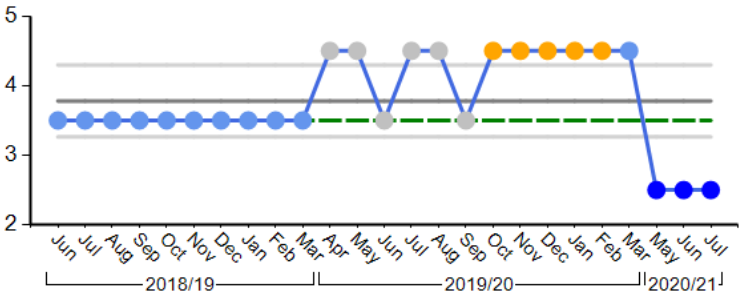
Capital Service Capacity



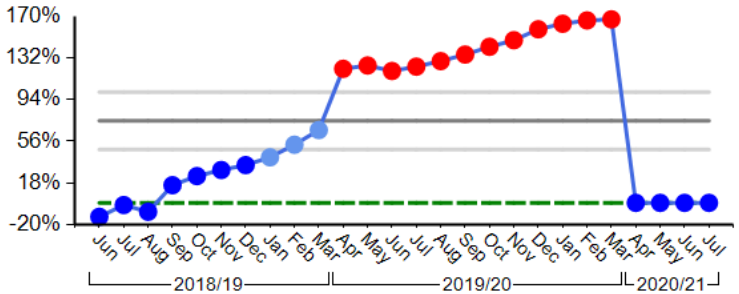
% Agency Staff (cost)



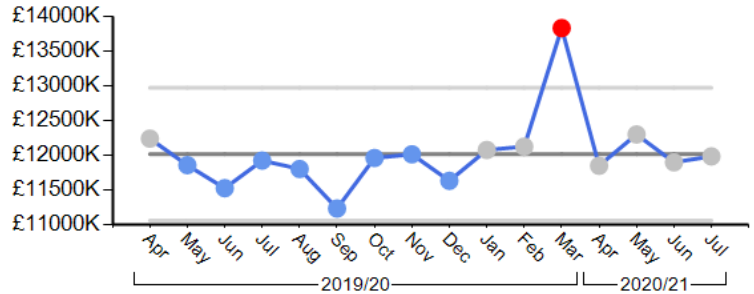
Use of Resources (Finance) Score



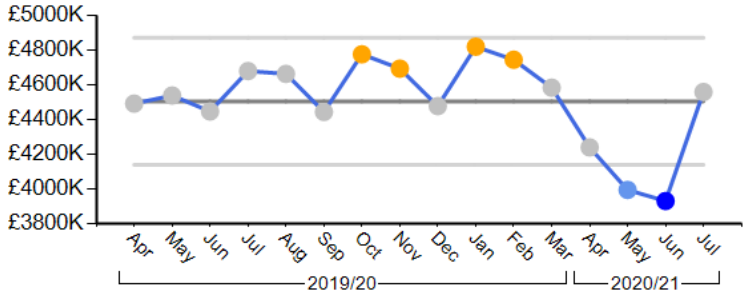
Distance from Agency Spend Cap



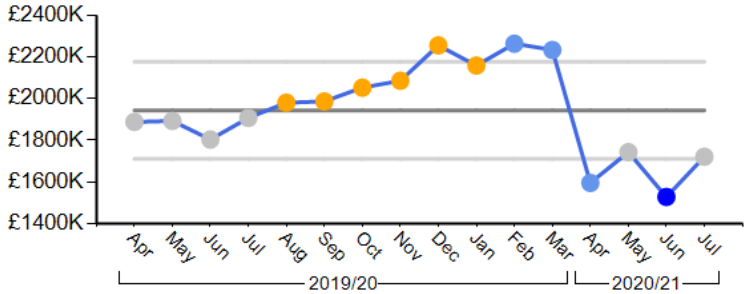
Pay Run Rate - Trust



Non Pay Run Rate - Trust



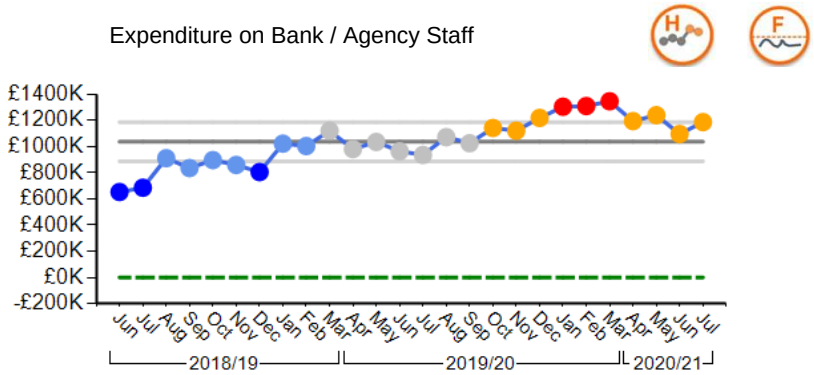
Bank & Agency Run Rate - Trust



Workforce

Agency

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Expenditure on Bank / Agency Staff	£00K	£1,186K	N/A	Jul 20	H	£00K	£1,095K	Jun 20		£4,715K	F



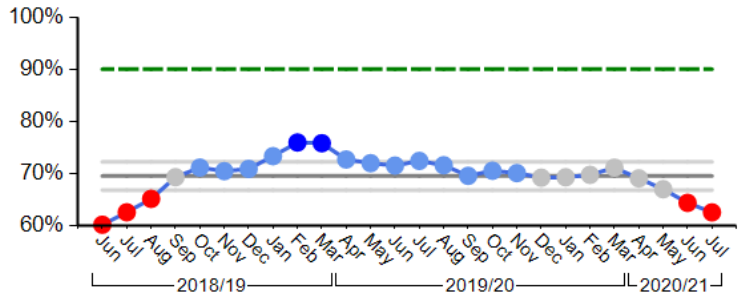
Workforce

Organisational Development

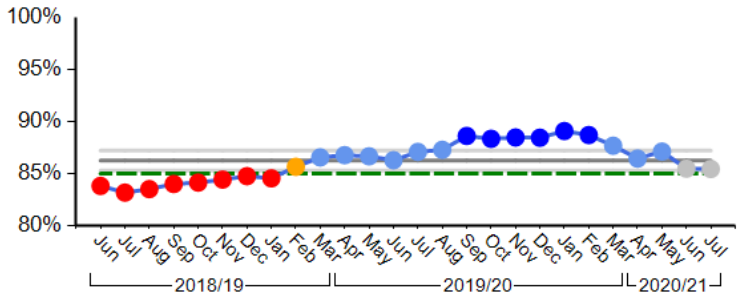
Analyst Narrative: PDR performance falls again, this is the fourth consecutive month this has dropped.
Operational Narrative: The Trust core mandatory training figure has overall shown a deteriorating picture since February 2020 and remains just above the Trust compliance target at 85.4%. From April 2020, corporate induction has remained on hold due to Covid and social distancing rules; new starters have been advised to complete all training online. This may have had an impact on staff entering the workplace with training incomplete and a review is underway to understand any impact better. Line managers will be contacted with data & details on how new starters can update (Aug/Sept 2020). A new virtual welcome programme is due to commence Q3 with eLearning remaining the principal method of core mandatory training moving forwards. Face to face training for practical sessions remains difficult but where possible, staff either complete online or via small bespoke face to face sessions. Clinical induction was reinstated (July 2020) as a 4 day programme due to the smaller numbers, this will improve compliance data.
A MIAA Audit will commence August2020 for 3 months to review data management processes, this will build on the outcome of the 2018 report when 'significant assurance' was found. The Induction & Mandatory Training Policy will be reviewed in Q3 in line with the significant impact Covid has had on training compliance.
The Trust's extreme risk around the clinical competence of the multi-professional workforce has been reviewed by the Executive Team and broken down in to three risks with a focus on 1) oversight of clinical education (education governance), 2) lack of assurance around recording and reporting processes, and 3) infrastructure and resources to deliver clinical education. These risks are reviewed monthly by the Risk & Compliance Group led by the CEO. An Executive Clinical Education Oversight Group has been established to meet weekly to review and progress actions.
A Clinical Competency Working Group (CCWG) meets monthly to review the role specific clinical training requirements. The CCWG is also reviewing the training for the NHSP flexible worker group to provide assurance, and a further project is underway to establish an improved recording & reporting process for our medical trainees via STEP (System-wide Training & Employment Passport).
Core mandatory & role specific training are also monitored by the Quality & Safety and Workforce Committees, and CBU's are held to account through the PIDA process.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	90%	62.6%	N/A	Jul 20	L	90%	64.4%	Jun 20	90%	66.8%	F
Mandatory Training	85%	85.4%	N/A	Jul 20	H	85%	85.5%	Jun 20	85%	86.1%	?

Personal Development Review



Mandatory Training



Workforce

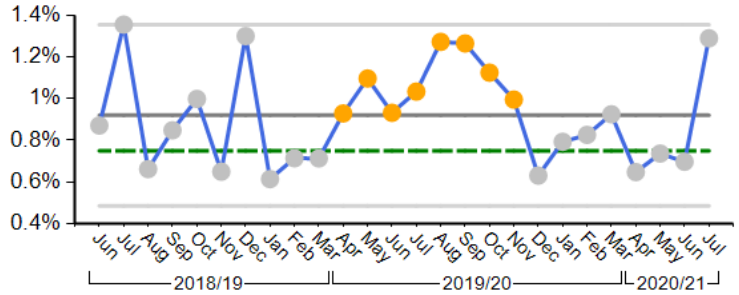
Sickness, Vacancy and Turnover

Analyst Narrative: Staff Turnover increased to the level of July 19 following 3 months of being within the target however this may have been due to inactivity in the job market due to Covid.

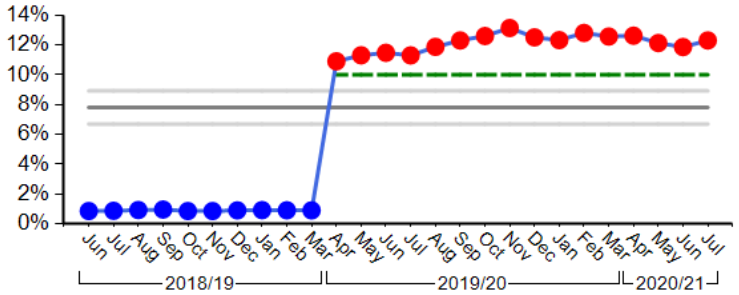
Operational Narrative: Time to hire continues to improve with active reviews and monitoring in place to identify underlying issues and contributing factors. Staff turnover showed a significant in month increase which reflects the one off impact of the end date of students who opted in to support the trust through the response to Covid 19. Staff turnover will remain high next month as a result of the annual junior doctors changeover. Agency reduction plan are in place in relation to Nursing temporary staffing and in relation to reginal collaborative medical bank development which are expected to deliver reductions in agency spend in the next 3 to 6 months.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Staff Turnover	0.75%	1.3%	N/A	Jul 20		0.8%	0.7%	Jun 20	9%	6.8%	?
Staff Turnover (Rolling)	10%	12.3%	N/A	Jul 20	H	10%	11.9%	Jun 20			P
Vacancy Rate - Medical	5%	14.5%	N/A	Jul 20	H	5%	13.9%	Jun 20	5%		F
Vacancy Rate - Nursing	8%	15%	N/A	Jul 20		8%	15%	Jun 20	8%		F
Sickness Rate	4%	4.8%	N/A	Jul 20	H	4%	5.5%	Jun 20	5%	6.9%	?
Sickness Rate (Rolling 12 Month)	4%	5.9%	N/A	Jul 20	H	4%	6%	Jun 20	4%	5.9%	F
Time to Recruit	55	50	N/A	Jun 20	L	55	47	May 20	55	49	?
Sickness Rate - Medical Staff	4%	1.9%	N/A	Jul 20		4%	2.2%	Jun 20	4%	4.1%	?
Sickness Rate - Nursing Staff	3.7%	5.5%	N/A	Jul 20	H	3.7%	6.5%	Jun 20	3.7%	8.6%	F
Sickness Rate - Non-Clinical Staff	4%	5.1%	N/A	Jul 20		4%	5.7%	Jun 20	4%	6.1%	F
Sickness Rate (not related to Covid 19) - Trust		4.1%	N/A	Jul 20			4.2%	Jun 20		4.2%	?

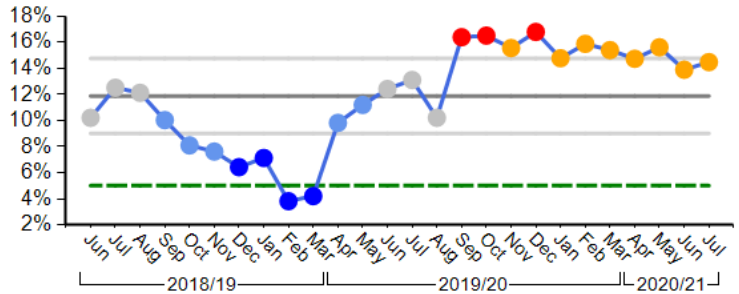
Staff Turnover



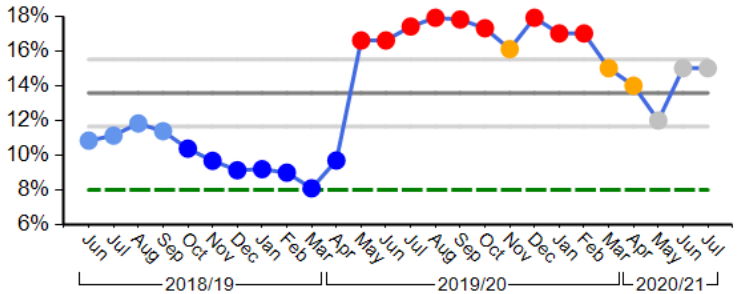
Staff Turnover (Rolling)



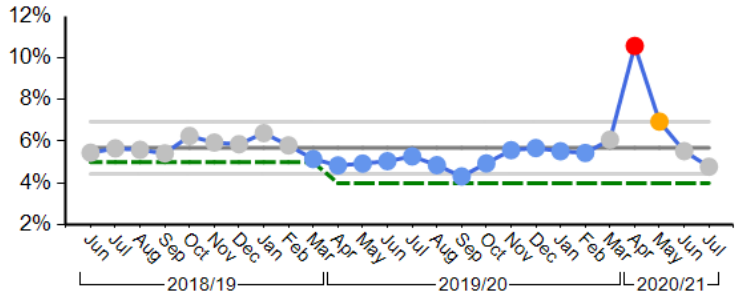
Vacancy Rate - Medical



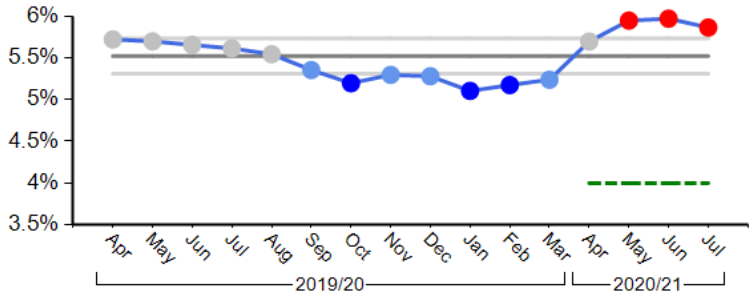
Vacancy Rate - Nursing



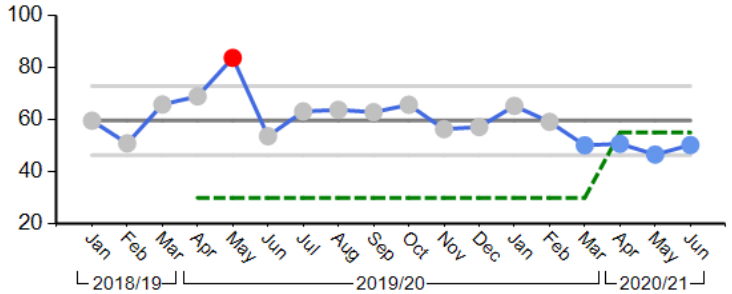
Sickness Rate



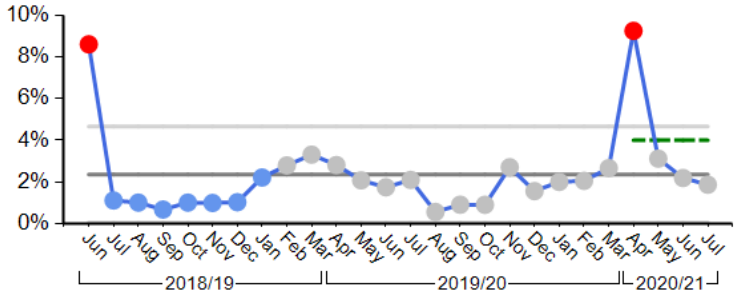
Sickness Rate (Rolling 12 Month)



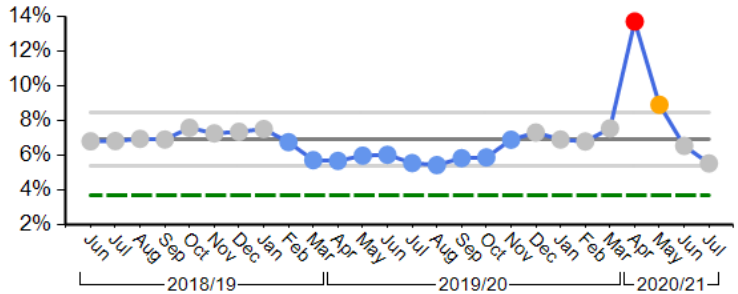
Time to Recruit



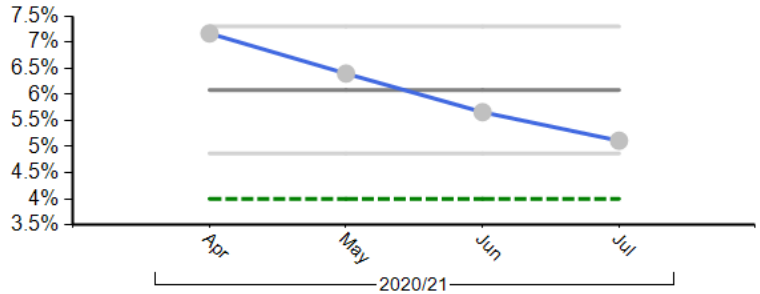
Sickness Rate - Medical Staff



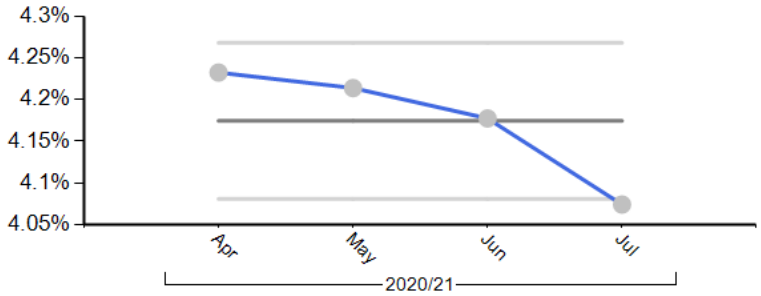
Sickness Rate - Nursing Staff



Sickness Rate - Non-Clinical Staff



Sickness Rate (not related to Covid 19) - Trust



Alert, Advise, Assure (AAA) Highlight Report

Committee/Group	Workforce Committee
Meeting date:	28 July 2020
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Clinical Competence
The Committee were advised that progress is being made against this risk and it is being monitored heavily by the Quality and Safety Committee and the Risk and Compliance Group. The extreme risk is split into three separate areas: delivery and training, oversight of the training and educational offer across organisations, and recording and reporting around levels of compliance; to enable the issues are addressed cohesively. The risk sits under the portfolios of the Director of HR & OD, Director of Nursing, Midwifery and Therapies and the Medical Director. Further updates to be provided to the Workforce Committee next month.

ADVISE

Safe Staffing
For the month of June 2020 the Trust reports safe staffing against the national average (90%) at 89.95%, comparable to the overall fill rate from the previous month. it was noted in the Committee that the Health Care Assistant Band 2 and 3 vacancy rate (14.81 WTE) for inpatient ward areas has increased from last month due to the student nurses which have increased due to COVID-19.

BAME Questionnaire
The Committee acknowledged the low 9.5% response rate and noted that there was a high level of interest in a further face to face support group where it is hoped to gather further insight. In addition 98% of risk assessments for this group have been completed.

Health Education England (HEE) Contract
From a nursing perspective, 81 student numbers will increase from September 2020 onwards across UCLAN, Edgehill and Liverpool John Moores universities as part of the Clinical Placements Expansion Programme for the northwest region. Therefore the Trust we has joined the collaborative bid for the HEE monies (£50,000). In addition, in Apprenticeships, HEE are lobbying the government so that funding isn't reduced during COVID-19.

Core Mandatory Training
Compliance for Core Mandatory Training has decreased in month to 85.5% from 87.12% in June 2020. It was noted in the Committee this is due to many reasons such as shielding of staff throughout COVID-19. The Performance, Improvement, Delivery and Assurance Board have discussed with the CBUs how this figure can be increased.

E-Rostering
The Committee were informed that the E-Rostering and Medical Taskforce group has been re-established after COVID-19 to complete the NHSI Levels of Attainment (LOA) requirements. The E-Rostering team have controls in place to deliver the nursing roster, and the Terms of Reference for the nursing Check and Challenge meetings has been revised. There is concern about the engagement aspect of job planning and achieving Levels 3 and 4 in the LOA without Executive sponsorship to gain traction.

ASSURE

Apprenticeships
Whilst the Digital Apprenticeship System is showing discrepancies, the Trust has still not lost any funding for apprenticeships. During COVID-19, the Trust saw a decrease in the number of new registrations of apprenticeships, but ultimately didn't pause the system unlike other organisations. The Committee recognised the work of the Apprenticeship Lead who is continuing to ensure we are in a safe position going forward.

Empactis System
The implementation of the Empactis System was paused during COVID-19 but has now restarted with key stakeholders getting progress back on track. Rapid deployment of the absence functionality has been live since May with SitRep and Swab list functionality available to be operational if required.

Staff Turnover
Whilst the Committee had a number of queries regarding the intricacies of the data detailed in the report, the membership was assured by the provided information: it was indicated that the Trust is aware of the distorting patterns in the data which is linked to Jnr Dr rotation. The Committee requested a review of presentation of the data.

Employee Relations (ER)
The Committee were advised that the majority of ER cases were paused during COVID-19. The Head of HR and Staff Side Lead undertook a case review of the Trust's ER cases which was taken as example by the region on doing this effectively. Further information on the trend in dignity at work cases was requested by the Chair. Overall positive progress is being made.

Health and Wellbeing Action plan
The membership were impressed with the action plan, despite the number of Red and Amber BRAG rated risks as there were explanations and actions for each. The Assistant Director of Health and Wellbeing will be working with the Associate Director of Estates and Facilitates to further progress the plan.

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

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group	Workforce Committee
Meeting date:	25 August 2020
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

PDRs

Compliance for PDRs is at 62.6% in July 2020 against the figure of 64.4% in June 2020, against the target of 90%. The area is of great concern to the organisation to deliver a process which provides meaningful conversations and quality appraisals for all staff. In order to resolve the decline of compliance, the Workforce Committee are commissioning a deep dive analysis which will include objectives to identify contributing factors which affect quality and PDR compliance, and research of best practice and recommendations of action.

NHSP Performance

NHSP performance remains below the KPIs detailed in the contract; 59.10% of all shifts released through the roster were filled by Bank workers, 25.37% were filled by agency workers and 15.54% were unfilled in July 2020. The Resourcing team are ensuring they drive performance with NHSP fortnightly and work on the Collaborative Bank in the region to maximise alliance on bank instead of agency. The Committee discussed this in relation to temporary staffing with an agreement to prioritise urgent issues quickly, such as medical staffing.

ADVISE

Sickness Absence

The sickness absence rate for all staff groups: medical, nursing and non-clinical have begun to decrease to 1.9%, 5.5% and 5.1% respectively from their high levels during COVID-19. Whilst compliance for the medical staff group is below target, nursing and non-clinical sickness absence rates are still higher than their targets. Sickness absence has affected all Trusts in the region but unlike Southport and Ormskirk, those organisations with extremely high levels of absence have been formally written to. The Trust is continuing to work with Staff Side on supporting attendance at work. The Social Partnership Forum (SPF) agreement is still in place – see below.

Supporting Attendance Policy

The revised PERS 12 Supporting Attendance policy is unlikely to be launched on 1 September 2020 due to restrictions with the SPF agreement, however this will be renewed on 30 September. In the interim, the HR team are continuing to promote best practice and support shielding staff, specifically any cases that require intervening to progress quickly.

Time to Hire (TTH)

The average TTH performance has deteriorated in month to 66.18 days against the 55 day target. This has been greatly impacted by the TTH for medical and dental staff, specifically two consultants whose appointments experienced significant delays. The Committee discussed the Royal Colleges and their involvement in recruitment processes. It was agreed for the Director of HR & OD to escalate the Committee's comments to Anthony Hassall, Regional Chief People Officer.

People Plan

The NHS People plan will inform the HR/OD Strategy and strategic priorities will be reviewed. realigned and reported to Committee.

ASSURE	
Apprenticeships The Trust has still not lost any funding for apprenticeships despite the errors seen in the Digital Apprenticeship System. The Trust are expecting more registrations to commence and so is well placed to avoid losing monies. The Apprenticeship Steering Group meeting, which was stood down during COVID-19, was recently re-established. **MIAA Recruitment Review 2019-2020** The recruitment review from MIAA for 2019-2020 provided substantial assurance. The Trust received some medium to low issues with timescales for completion and in-depth feedback. All deadlines for resolving these issues are on track.	
New Risk identified at the meeting	None.
Review of the Risk Register	

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**27 JULY 2020**
LEAD:	**DR DAVID BRICKNELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The availability of more detailed reports for both Quality Improvement and CQC compliance show areas of the hospital where we were not completely assured as to the root cause of the problems. CBUs will be attending in future to both explain and reinforce accountability.

ADVISE

- End of Life national audit had shown a drop in our performance relative to other Trusts. The achievements of the Oasis Ward had shown we have the expertise and culture to deliver outstanding care, but this has to be translated into our everyday activities.
- Matters covered by the MIAA limited assurance report are being addressed and benchmarked targets are in place for achievement by September.
- Mandatory Training shortfalls in certain areas are shown by more detailed reporting. Although some face to face training has suffered with COVID, these areas can now be supported to ensure target levels are met across the hospital and not just on average.
- The annual drugs and therapeutics report showed significant improvements, but there were still areas of detailed practice to be addressed at ward level and the Medical Gases Policy and Medical Gases Committee required urgent attention.

ASSURE

- The HMSR mortality comparison shows a continuing drop to well below the national average. Over a period of 18-24 months the hospital had moved from one of the worst performers to one of the best. A report on the mechanisms of this would be prepared for sharing with others and to review whether there was learning for other areas in our performance.
- The Perfect Ward app was already delivering real time audit for teams across the hospital, and this, in conjunction with SONASS, gives us the material to continually monitor and improve.
- Infection, Prevention & Control Annual Report gives significant assurance on overall performance. Wider attribution of responsibility for C-Diff and the relatively poor performance on blood culture contamination both are receiving particular focus.
- The Annual Research Report shows an area of excellence from a small team which should be shared more widely. We continue to retain all of our central funding by meeting stretching targets and we lead in recruitment to national studies, as well as being awarded in the orthopaedic field.

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

Review of the Risk Register

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

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

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The project to address lost to follow-up patients has to date reviewed over 12,000 files. The project is to be reviewed to determine the manner and cost of another potential 200,000 files. There is a risk stratification process in place. There have been a number of cases that have been investigated through the Trust incident management systems. 10 have been graded as moderate harm and some as minor harm.

ADVISE

- With the change of responsibilities at Executive level, Dr Hankin will ensure that there is no loss of focus in relation to medical gases, both policy and training.
- Fragile Services is an extreme risk, and there is a significant and complex programme of work which will be reported back to the Committee in October.
- Covid Phase III planning is working internally and with the System to meet the challenging and rapidly evolving requirements of the regulator.
- The Quality Improvement Programme reveals significant progress, but there is still scope to improve in some areas and with some individuals.
- Spot checks, the subject of the MIAA Audit have improved, but best practice is complex and a detailed action plan will be reviewed by the Committee to establish appropriate targets and actions.
- There are still gaps in mandatory training, significantly where face to face training had to be postponed. Better reporting is clarifying the gaps and the return to business as normal will put training at the forefront.
- Whilst there are still a number of out of date policies, these are now clearly identified and a programme of review and approval in the short term is now in place.
- The governance structure for Health and Safety has been strengthened but there are challenges to meet the requirements of fire safety inspections given the nature of our estate.

ASSURE

- Quality Impact Assessments are well embedded and this will also cover the safe return to the targeted levels of Phase III activity.
- Good progress is being made in CQC actions, including the well-led category, but we need to examine the visibility of the Board, particularly the NEDs, in clarifying and reinforcing the communications.
- An agreed and novel structure will enable us to launch the Medical Examiner's Office in the near future which will enable us to meet the target of 100% screening of deaths and the proper programme of SJRs.
- The Cancer Services Annual Report shows outstanding and nationally recognised work in support of our patients. The team has been able to keep in touch with all cancer patients throughout lockdown and will put us in a good position to minimise delay in Phase III.
- Clinical Audit Annual Report shows a high quality of work and significant assurance.
- The Integrated Governance Report showed great improvement in relation to complaints and the team are now achieving the targeted timescales.

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 September 2020**
Agenda Item	**TB133/20**	**FOI Exempt**	**No**
Report Title	**Infection Prevention and Control Assurance Framework**		
Executive Lead	Bridget Lees, Director of Nursing Midwifery and Quality/DIPC		
Lead Officer	Andrew Q Chalmers, Consultant Nurse/Deputy DIPC		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

The purpose of this paper is to present the Infection, Prevention and Control (IPC) Assurance Framework 2020/21 for approval and provide assurance that the Trust is progressing with its IPC objectives.

Executive Summary

The IPC Assurance Framework was introduced in May 2020 by the NHS England Chief Nurse in response to Covid 19. The self-assessment framework has been developed in conjunction with existing legislative duties within the Health and Social Care act Regulation 12, Regulations 2014. It is required to be evaluated at Trust Board and will be presented quarterly going forward. The Assurance Framework criteria was subsequently amended nationally, and version 1.2 is being presented in this paper. Board members will be advised as versions are updated throughout the year in terms of changes.

As part of the assurance processes, there is a requirement for each organisations IPC Assurance Framework to be assessed by the CQC, followed by a series of interviews with the DIPC and Infection Prevention team. The Trust was assessed on 31 July 2020, and the process concluded that there was assurance that the Trust has effective infection prevention and control measures in place with regards to Covid 19. The CQC's full response letter is enclosed as an appendix in this paper for ease of reference.

The current BAF demonstrates process against requirements. The area to note rated Amber is related to hand dryer removal, which is an addition to the BAF as part of version 1.2. For assurance, there is a plan to complete this work, which will be monitored by the Infection Control Assurance Committee and the Quality and Safety Committee. Ongoing monitoring arrangements have been built as part of an audit programme to ensure there is continual monitoring of the IPC AF, which will also be reported through committee structures each quarter.

Recommendations

The Board is asked to receive the IPC Programme and BAF and acknowledge the 1st quarter report and support the ongoing IPC programme with BAF and the actions identified within the report.

Previously Considered By:

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

Southport and Ormskirk Hospital NHS Trust

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:**
Andrew Q Chalmers	Andrew Q Chalmers

Publications approval reference: 001559

Infection prevention and control board assurance framework

22 May 2020, Version 1.2

Updates since version 1, published on 4 May 2020, are highlighted in yellow

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Timescales	BRAG Rating	New Rating
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	Risk assessment templates used in Adult ED, Children's ED and Maternity.	Need to be reviewed / audited to ensure templates are included in notes.	Documentation audit to be completed	Report in July 2020		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Reviewed following updated guidance in relation to swabbing all admitted patients. As part of surge plan Covid-19 wards identified, BI dashboard allows bed managers to review status of patients. Asymptomatic patients awaiting swab results are risk assessed and co-horted.	Potential Asymptomatic co-horted may be in incubation, therefore risk of infecting other patients	Risk assessments in place. Patients moved accordingly.	Complete / Embedded May 2020		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Intermediate care facilities available for both positive and negative patients. Patients are swabbed prior to discharge or transfer. All patients discharged are given relevant information	A limited number of 'fast-swabs' are available, potential for patients to be in hospital longer waiting for discharge or transfer. As a result of this the process has accommodated this problem – when a patient is ready for discharge a swab completed to eliminate any delays for the patient.	Daily Care home call in place	Complete / Embedded May 2020		

• **all staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	PPE available and issues escalate via Silver / Phase 2. Comms circulated to staff if / when guidance changes. Additional training and information available for donning and doffing – enhanced level of training in place. Staff also encouraged to log any concerns or incidents on Datix Since June 2020 wearing face mask correctly posters has been provided through Trust news and posters around hospital	Few incidents have been reported	Incidents to be reviewed as part of Health and Safety review led by Health & Safety Team Monthly Audits recommenced in May 2020	Complete / Embedded May 2020 Report in July 2020		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Yes, single point of contact (SPOC) e-mail monitored 7 days. Disseminated through CBU & Support Cells (previous Silver, Bronze) and Gold to wards, clinical and corporate areas.	Potential that not all guidance can arrive via SPOC	Log all IPC related guidance not received via SPOC to SOS Cell.	Complete / Embedded May 2020		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	As above, risks in relation to Covid-19 (PPE, equipment, service moves and staffing). Reviewed by Gold, CRG and Board. Also discussed in CBU and support cells and Business with Covid programme	Potential that not all guidance can arrive via SPOC	Log all IPC related guidance not received via SPOC in Silver or SOS Cell	Complete / Embedded May 2020		

	board					
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	Yes, Covid-19 related risks reviewed on weekly basis and reported through Gold, EMT, QSC (monthly) and Board (monthly)	Yes	N/A	Complete / Embedded May 2020		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Monthly IPC report to be reviewed (summary produced until June 2020). Quality Priority (including IPC) monthly reports submitted to QSC and Board. Audits restarted, annual report complete July 2020	None	N/A	Report in July 2020 and Annual Report		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Timescales	BRAG Rating	New Rating
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	IPC mandated training continues, there's also enhanced donning and doffing, PEF Team are also providing training. U Tube video remains on line and latest guidance available on intranet and in clinical areas	Potential gaps in training records because some records are hand written and not electronic	Discussions ongoing with Training, IPC and BI – needs to continue into Phase 2 Lead to be identified to take forward Training records for fit testing and Clinell Ready Rooms have been electronically recorded by BI Team	July 2020		

			IPC e-learning includes appropriate use of PPE and is recorded by training department.			
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Specific training has been provided for cleaning staff including enhanced donning and doffing and fit testing.	Potential gaps in training records, some records manual and not electronic Update – now have training record for facilities staff (fit test) and annual staff competencies	Training records have been provided by Facilities manager	July 2020		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Yes –cleaning schedule in place. IPC team confirmed we use chlorine dioxide above the recommended guidance Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x between 07.30-23.00	Potential gaps in rotas due to staff absence	Any gaps are being covered with agency and Trust own staff doing additional hours – no issues reported	Complete / Embedded May 2020		
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Yes, A&E and ITU have dedicated cleaning teams. Enhanced cleaning schedules in place in line with national guidance Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x between 07.30-23.00	Potential gaps in rotas due to staff absence	Any gaps are being covered with agency and Trust own staff doing additional hours – no issues reported	Complete / Embedded May 2020		

• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Domestic Cleaning schedules have been revised and updated in clinical areas, communal areas Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x between 07.30-23.00	Potential gaps in rotas due to staff absence	Any gaps are being covered with agency and Trust own staff doing additional hours – no issues reported	Complete / Embedded May 2020		
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Trust uses Tristel disinfectant/cleaner containing chlorine dioxide throughout the Trust. Also use Clinell universal wipes which meet criteria specified in national guidance	None Reported	N/A	July 2020		
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	Domestic Staff – instruction included in cleaning procedures. Communications reminder to be shared with clinical and corporate staff	Potential Gap – awareness for clinical and corporate staff	IPC and Communications Team to circulate alert regarding disinfectant products to make sure you allow to air dry for at least 60 secs	End July 2020		

• as per national guidance:'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	Domestic Cleaning schedules have been revised and updated in clinical areas Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x between 07.30-23.00	Potential gaps in rotas due to staff absence	Any gaps are being covered with agency and Trust own staff doing additional hours – no issues reported	Complete / Embedded May 2020		
• electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Ward and clinical area staff to undertake this. In CMO staff who are hot desking are reminded to clean desks and equipment with universal wipes.	Potential for staff not to do this.	Reminders to be circulated in Trust News and ward / clinical area communications	End July 2020		
• rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Domestic Cleaning schedules have been revised and updated in clinical areas, Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x between 07.30-23.00	None reported	N/A	July 2020		

• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Laundry bagged in calcium alginate bags then wrapped in clear plastic packaging	Gaps when outer plastic bags have not been used due to stock issues (No longer issue)	Additional stock ordered. New communications reissued – Resolved	Resolved April 2020		
• single use items are used where possible and according to Single Use Policy	Yes, Single Use Policy is included in IPC Manual	Current exception is CPAP hoods which are being reprocessed due supply issues, this is included on risk register (No longer issue)	Now resolved Procurement has been able to source additional hoods.	Resolved May 2020		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Yes, all through HSDU. Beds and equipment are wiped down with disinfectants.	Non reported	N/A	Complete / Embedded May 2020		

• review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	Reviewed by Estates and IPC Teams	Areas are ventilated but no cooling	N/A	July 2020		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	Daily Intensive Care Unit ward rounds have been maintained as previously, as have weekly C. difficile ward rounds. NICE gap analyses are all up to date. Regular monitoring of antimicrobial resistance on the Spinal Injuries Unit is still being maintained, as planned following an outbreak of a Gentamicin-resistant Gram negative organism last year. Antimicrobial stewardship committee has met on 10 June 20 prior to this activities have been ongoing remotely, e.g. review of adult antimicrobial guidelines which was due at this time.	Antimicrobial Pharmacist on maternity leave.	Resolved - Covered by wider team. Temporary replacement pharmacist has now been identified – due to start September 20	May 2020		

	Changes for the new adult guidelines have been sent out to the Antimicrobial Stewardship Committee as well as trust wide via trust email and directly to relevant Clinical Directors		New adult guidelines awaiting final sign off from Drugs and Therapeutics Committee on the 30.07.20; plan for guidelines and app to go live on Wednesday 5th August.	5 August 2020		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Yes via AAA (Drugs and Theraputics Committee and IPC Assurance Committee to Quality & Safety Committee)	No Gaps	N/A	Complete / Embedded May 2020		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Timescales	BRAG Rating	New Rating
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	Yes, reviewed and implemented before 8th April 2020	Any concerns raised picked up by PICO team	Exceptions for some EoL patients and birthing partners in Maternity	Complete / Embedded May 2020		

• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Yes, updated signage and PPE stations in every clinical area and through both sites.	None	N/A	Complete / Embedded May 2020		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Yes and recorded message on Trust telephone.	Compliance checked with Equalities and Diversity Lead	Available for deaf community and link to translation website	Complete / Embedded May 2020		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Yes, included in discharge summary and discussed with discharge planners and coordinators	Need to audit to check this information is being communicated	Audit to be undertaken – Patient Flow Team	Reporting July 2020		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**
Systems and processes are						

in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection as per national guidance	Reconfiguration of adults and children's ED and Maternity services. Signs are displayed at all entrances. Additional reconfiguration in other clinical areas in line with surge plan – QIAs completed and in place	Non reported	Regularly reviewed and evaluated by Health and Safety and IPC Team On-going review of signage as guidance changes during phase 2	Complete / Embedded May 2020		
• mask usage is emphasized for suspected individuals	Mask are provided for all patients and staff as they come through front doors.	Non reported	N/A	June 2020		
• Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	We have segregated patients and in addition we have screens for reception staff and volunteers at front door	Non reported	N/A	June 2020		
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible	We isolate patient with new onset symptoms and investigate potential contacts Labs report cases and PHE instigate track and trace	Non reported	Any patient from care home, IPC team contacts community IPC nurses	July 2020		
• patients with suspected COVID-19 are tested promptly	Yes, all admissions are now screened; patient status is displayed on BI Patient Location dashboard. Inpatient swabbing continues	Non reported	SOP in place, will be regularly reviewed in line with any new guidance	Complete / Embedded May 2020		

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Risk assessments completed for admissions and patients co-horted or allocated side rooms accordingly. Status data is displayed on BI dashboard – different status are colour coded	Patient could become positive whilst in an 'asymptomatic' bay or potential to develop Covid from positive patient	Patients moved to appropriate area based on clinical need. IPC Team to liaise with Patient Flow Team and Business Intelligence Team	Complete / Embedded May 2020 30 June 2020		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	SOPs in place, patients are risk assessed and swabbed (where appropriate)eg GAB, Maternity, Cancer, Outpatients and Radiology Virtual appointments are / will be offered where appropriate	Non reported	Cancer patients are swabbed and their specimen fast tracked	Complete / Embedded May 2020		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**

Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	IPC mandated training continues, there's also enhanced donning and doffing, PEF Team are also providing training. U Tube video remains on line and latest guidance available on intranet and in clinical areas Numerous educational posters circulated throughout the hospital and clinics Specific training has been provided for facilities, estates and contactors staff including enhanced donning and doffing and fit testing.	Potential gaps in training records, some records manual and not electronic	Discussions ongoing with Training, IPC and BI – needs to continue into Phase 2 Lead to be identified to take forward Training records for fit testing and Clinell Ready Rooms have been electronically recorded by BI Team. Staff working in clinical areas required to receive annual mandatory IPC training Trust bulletins sent to all employees regarding safety measures	July 2020		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	IPC mandated training continues, there's also enhanced donning and doffing, PEF Team are also providing training. U Tube video remains on line and latest guidance available on intranet and in clinical areas	Potential gaps in training records, some records manual and not electronic	Discussions ongoing with Training, IPC and BI – needs to continue into Phase 2 Lead to be identified to take forward Training records for fit testing and Clinell Ready Rooms have been electronically recorded by BI Team	July 2020		

• a record of staff training is maintained	IPC mandated training continues, there's also enhanced donning and doffing, PEF Team are also providing training. U Tube video remains on line and latest guidance available on intranet and in clinical areas Yes, for mandatory training, sign in sheets are available for enhanced or specific training	Potential gaps in training records, some records manual and not electronic	Discussions ongoing with Training, IPC and BI – needs to continue into Phase 2 Lead to be identified to take forward Training records for fit testing and Clinell Ready Rooms have been electronically recorded by BI Team	July 2020		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Existing CAS alert process is still in place and escalated via Silver Command or SOS cell	Non reported	N/A	Complete / Embedded May 2020		

• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Any incidents will be recorded in Datix and investigated accordingly	Communications to staff to remind them to Datix any issues	Comms have been circulated, any incidents are managed via daily incident meetings and SIRG if applicable and with Health & Safety	Complete / Embedded May 2020		
• adherence to PHE national guidance on the use of PPE is regularly audited	IPC Audits have recommenced and are undertaken monthly	None	Monthly Audits recommenced in May 2020	Reporting July 2020		
• staff regularly undertake hand hygiene and observe standard infection control precautions	Process in place for hand hygiene audits and standard IPC observations, however not as frequent in recent months	Frequent visits to wards by IPC and Corporate nursing, but lacking in documentation	Monthly Audits recommenced in May 2020	Reporting July 2020		
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is	Areas with hand dryers have been identified.	Hand dryers are only in staff and public toilets	IPC liaising with Health & Safety and Estates (completing a risk assessment) regarding isolating hand dryers Requested Estates to deactivate hand dryers and procurement to supply paper towels and dispensers	July 2020		

located close to the sink but beyond the risk of splash contamination, as per national guidance						
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Wipeable signs and pictorial guides on hand hygiene posted in public and staff toilets	Areas having recent refurbs may not of had sign/posters placed!	Provide domestic team leaders with posters that can be replaced as necessary	Complete July 2020		
• staff understand the requirements for uniform laundering where this is not provided for on site	Yes, this has been communicated to staff through communications.	Concern raised by staff side, communications to be circulated	Resolved - Further communications circulated to staff	Complete / Embedded May 2020		

• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Yes, this has been communicated to staff through communications. SOP including flow chart in place explaining how to contact absence line and swabbing referrals	Any issues raised are picked up individually by HR & OD	SOP in place, will be reviewed as guidance is updated	Complete / Embedded May 2020		
7. Provide or secure adequate isolation facilities						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	As per surge plan, there are designated COVID and non-COVID wards and cohorted bays and side rooms, for additional isolation capacity Clinell Ready Rooms are available.	Limited availability of Side Rooms	Bed base reviewed by Bed Manager, Clinell Ready Rooms are available. In the event of a further spike, Trust will move into Flu Pandemic mode (as per Phase 1 of Covide-19)	Complete / Embedded May 2020		

• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Yes all compliant	Limited availability of Side Rooms	Bed base reviewed by Bed Manager, Clinell Ready Rooms are available From cleanliness perspective, cleaning supervisor audits not regularly completed. Process in place to restart and designated supervisor to monitor audits and provide training - completed	Complete / Embedded May 2020		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Yes, IPC Team epidemiology package IC net interacts with Lab Systems or PAS systems	Non raised	N/A	Complete / Embedded May 2020		
8. Secure adequate access to laboratory support as appropriate						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Yes, testing undertaken by labs at SH&K Trust, comply with all clear national guidance	Non raised	N/A	Complete / Embedded May 2020		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Yes, Trust commenced staff testing with private provider early March 2020 prior to national requirement	Non raised	N/A	Complete / Embedded May 2020		
• screening for other potential infections takes place	Yes, also screen for flu, MRSA, Strep, Legionella	Non raised	N/A	Complete / Embedded May 2020		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Timescales	BRAG Rating	New Rating
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC Policy and Covid Policy (including SOPS) are available to all staff via intranet or paper copy IPC Staff also on site 7 days a week and on call provided by microbiologist	Non raised	N/A	Complete / Embedded May 2020		

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Yes, changes to national guidance are reviewed at Silver (now replaced by operational cells) and Gold, changes / amendments to policy and SOPs are cascaded via Comms Team and by IPC Team	Non raised	N/A	Complete / Embedded May 2020		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All waste from COVID confirmed or suspected patients is disposed of in Orange bags and classed as infectious clinical waste suitable for alternative treatment.	Some historic mixing of waste bags due to insufficient storage space.	All waste from clinical areas at Southport is currently classed as infectious therefore no issue with mixing of clinical waste	Complete / Embedded June 2020		
• PPE stock is appropriately stored and accessible to staff who require it	Yes, stored in dry, cool store with appropriate security	Initial issues regarding security, now resolved	Security revised and access to stores reviewed	Complete / Embedded May 2020		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Timescales**	**BRAG Rating**	**New Rating**

Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Poster developed to aid staff and managers to identify 'extremely vulnerable' and 'at risk' staff. This has been communicated via the daily communications and in the 'staff zone' • Risk assessment developed to support managers and staff in mitigating risks. • Self-referral form specifically for COVID-19 queries developed and circulated via daily communication and on 'staff zone' • COVID-19 poster 'it ok not to be ok' developed and circulated in COVID-19 comms and displayed in all areas. • We have 7 day provision to advice OH advice • To date the OH&W team have provided specific advice to over 1,800 staff calls, in addition to responding to emails and supporting managers and staff with the risk assessment process • We are continuing to provide counselling both face to face and remotely. • Our OD team have developed resources and produced a 'wellbeing pack' that has been distributed to departments at both sites to encourage **Well Being Walls:**	Non currently highlighted	Will respond and update to any further guidance	Complete / Embedded May 2020		

	33 departments in Ormskirk 35 departments in Southport. • Our OD team is providing 'coaching' face to face and remotely. • Boo Coaching are also working with H&W and our OD team to support the wellbeing of our staff.					
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	FFP3 respirators currently in use in addition some PAPR respirators are also being used; SOP in place regarding use and maintenance. Trust identified reusable respirators that can be used and where they can be located. Procurement is reviewing numbers required and cost and will then report to Gold	Limited face to face training provided to those who require PAPR	Training programme has been developed and is recorded appropriately, this will be incorporated into induction training for all new employees going forward	July 2020		
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and	There is a general principle that staff are not moved between wards unless there is an urgent need due to clinical need (cover wards). In general staff remain where they are allocated	Movement of ward staff to cover shifts (Safe Staffing)	If reallocation required this is advised to occur at the start of shifts to decrease the risk of cross contamination	July 2020	? Green	

emergency care pathways, as per national guidance						
• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Yes, corridors, restaurant and CMO have markings, one way system and posters in place. Masks are provided at all entrances and in all areas (offices and clinical)	Potential some areas where staff cannot social	Advice for staff to wear mask if not able to social distance	June 2020		
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Yes consideration has been given, communications have been circulated to all managers and staff Within staff restaurant social distancing measures have been introduced and monitored by catering staff Agile working has been introduced so staff who don't need to be on site can work from home or other bases	Non reported	N/A	June 2020		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• HR have set up an absence line, all staff report all absence including self-isolation. • The absence line team (HR) provide a daily report for the swabbing team. • Staff who are self-isolating have been	Non currently highlighted	N/A	Complete / Embedded May 2020		

	getting a call from HR or a Non-Exec.					
• staff that test positive have adequate information and support to aid their recovery and return to work.	Some Trusts are informing staff of swab results by text. All staff in our Trust who are swabbed receive a call from Staff Health & Wellbeing who provide specific advice to them and their families, this applies to those staff whose swabs are positive or negative.	Non currently highlighted	N/A	Complete / Embedded May 2020		

Infection Prevention and Control Assessment

Engagement call

Summary Record

Southport and Ormskirk Hospital NHS Trust

Provider address	Date
Town Lane Kew Southport PR8 6PN	31/07/2020

Dear Southport and Ormskirk Hospital NHS Trust

The Care Quality Commission is not routinely inspecting services during the pandemic period and recovery phase, although we will be carrying out some focused inspections. We are maintaining contact with providers through our usual engagement calls and by monitoring arrangements such as those for infection prevention and control.

This Summary Record outlines what we found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs.

We have found that the board is assured that the trust has effective infection prevention and control measures in place. The overall summary outlines key findings from our assessment, including any innovative practice or areas for improvement.

This assessment and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

Infection Prevention and Control – Assessment areas

1. *Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / isolation facilities?*	
Yes	The Board had received/undertaken a clear and comprehensive assessment of Infection Prevention and Control across all services including an assessment of the estate and isolation facilities.

2. *Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?*	
Yes	There are systems in place in manage and monitor the prevention and control of infection.

3. *Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?*	
Yes	There are systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections.

4. *Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?*	
Yes	There is appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

5. *Does the trust provide suitable accurate information on infections, in a timely fashion, to service users, their visitors and any person concerned with providing further support or nursing/ medical care?*	
Yes	The trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

6. ***Is there a system in place that ensures prompt identification of people who have or are at risk of developing an infection, so that they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people?***

Yes	The trust has systems to identify promptly people who have an infection, or who are at risk of developing an infection so that they receive timely and appropriate treatment.

7. ***Are there systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection?***

Yes	There are systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process or preventing and controlling infection.

8. ***Are there secure or adequate isolation facilities?***

Yes	The trust has effective process in place to manage the isolation of patients appropriately.

9. Is there adequate access to laboratory support?

Yes	There is adequate and responsive access to laboratory support.

10. ***Is there evidence that the trust has policies designed for the individual's care which will help prevent and control infections?***

Yes	The trust has effective policies designed for the individual's care which will help prevent and control infections.

11. ***Does the trust have a system to manage the occupational health needs of staff, regarding infection?***	
Yes	The trust has a system to manage the occupational health needs of staff regarding infection.

Overall summary record

High level information from IPC ESF call on 31/07/2020- Summary of discussion
1. No outbreaks – identified two clusters of 2 patients in the last 4 months these were addressed
2. Need to keep refreshing training and information due to “fatigue” of staff . Human factors. This includes making sure training in place, communication is thought of in different ways such as remote meetings, availability of guidance kept up to date and prompts to staff as they can and do change regularly.
4. Increased monitoring of patient moves to ensure that patents don’t move around areas frequently.
5. Some concerns around asymptomatic patients and some test anomalies that have led to retesting. Day 1 and day 5 is standard and again if symptoms persist despite negative testing. All patients risk assessed on arrival and cohorted within guidance.
6. Clear lines of cascade of information and monitoring of quality of service. Via gold command, Silver local Cells and IPC meetings.
7. Looking to bring back some visiting but how to manage that effectively. Had some concerns with patient communication i.e. next of kin, elderly population in the areas with widespread families sometimes next of kin wasn’t the most suitable person to communicate with so they have looked. Who is important to communicate with and how this is done. Opportunities for patients to undertake zoom calls etc.
8. Concerns regarding increased rates around them e.g. Blackburn and Darwin and impact of any in the rates in Southport
9. Also concerned about track and trace ramifications from that increase that may affect staffing levels but hasn’t at present.
10. Biggest concern going forward is as an old hospital there isn’t a big prevalence of side rooms. However, Trust have purchased 9 Clinell Readirooms (pop up isolation) to assist.
11. Robust auditing that is providing information including via perfect ward for areas such as antibiotics to inform management that is cascaded to board.
12. Testing remains prompt with the ability to respond in a timely manner.
13. Phase 2 planning is underway and reviewing potential reconfiguration in order to accommodate patient needs.
14. Meeting recent guidance such as removing hand dryers this is picked up and reported to board via BAF.
15. Single point of contact remains to ensure that the trust can be kept up to date with changes as this can be rapid in order to ensure latest guidance can be rapidly incorporate.
16. Reconfiguration of hospital with one-way systems to reduce potential cross

contamination and adherence that all staff wear masks.
17. Welfare support for staff continues and return to work managed. Coaching and counselling provision in place. OD support available as needed.
18. Information in a variety of formats available to patients' relatives and staff including leaflets, recordings, information on website and direct newsletters to staff.
19. Risks and gaps identified have planned mitigation in place that is monitored. Ingoing monitoring on none gaps as well to ensure that standards and quality remains.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**AUDIT COMMITTEE**
MEETING DATE:	**15 JULY 2020**
LEAD:	**Mr Jim Birrell**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Committee received the final version of the External Auditor's 2019/20 Annual Audit Letter and whilst it contained no surprises, there are two important points to note
  - the Auditors, (Mazars), have made a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 regarding the Trust's failure to achieve a rolling three-year break even position; and
  - the Value for Money conclusion stated that Mazars are *"not satisfied that the Trust had proper arrangements to secure economy, efficiency and effectiveness in its use of resources".* It also highlighted *"significant weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions".*

- Covid19 has had a big impact on Mersey Internal Audit Agency's to undertake on-site audit work so there has inevitably been slippage in the planned programme. However, work is picking up speed and there is optimism that the vast majority of the plan will be completed by the end of the financial year.

ADVISE

- A revised Board Assurance Framework format should be available for the next cycle of meetings.

- The Committee's Terms of Reference were agreed subject to the Chief Executive clarifying which Executive Directors will attend future meetings

- A review of the Freedom to Speak Up Annual Report broadened into a discussion on the Committee's duty to review the effectiveness of arrangements in place for allowing staff to raise, (in confidence), concerns about possible improprieties in financial, clinical or safety matters. In the absence of any subject experts, it was agreed that the Committee would in the first instance seek advice and views on the matter from the Workforce Assurance Committee.

ASSURE

- Work is progressing on the completion of the Register of Senior Staff and Key Decision Makers' Interests. Committee members felt that all relevant staff should be strongly urged to submit the requisite information, i.e. there should be no exceptions allowed.

- The Committee were pleased with the improvements made to the Corporate Risk Register and asked that a report outlining how the risk management system is now operating in practice be presented to the next meeting.

New Risk identified at the meeting	No new risks were identified at the meeting.
Review of the Risk Register	

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Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 SEPTEMBER 2020**
Agenda Item	**TB135/20**	**FOI Exempt**	**No**
Report Title	Committee Terms of Reference		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To purpose of this report is to present the Board Assurance Committees' Terms of Reference for approval following periodic review.

Executive Summary

The Board previously ratified the Terms of Reference (ToR) for all committees in July 2019 and these are now due for periodic review. All Committee Terms of Reference (ToR) were presented and approved by the respective Committees during July and August. However, the Finance, Performance, and Investment Committee ToRs, will be presented in October following the Committee's approval.

In line with best practice, all ToRs were reviewed to ensure they clearly define the Committee's functions and duties and are aligned to the Trust's Corporate Governance policies. The ToRs have also been refreshed to ensure they are consistent in style with those of other Board Committees. Notable changes from the previous versions are listed on the Version Control Document

Recommendations

The Board is asked to ratify the Terms of Reference following annual review by the respective Committees.

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:**
Sharon Katema, ADCG	Sharon Katema, ADCG

Southport and Ormskirk Hospital NHS Trust

Audit Committee

Terms of Reference Document Control Sheet

MEETING	Audit Committee
ESTABLISHED BY /REPORTING TO:	Board of Directors
Reviewer:	Sharon Katema, Associate Director of Corporate Governance
REVIEW:	July 2020
ASSOCIATED DOCUMENTS:	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED COMMITTEES /GROUPS	Board of Directors Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Charitable Funds Committee Workforce Committee Hospital Management Board

Document Control	
Document Name	Audit Committee ToR– July 2020
File Name	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\Audit Committee ToR – July 2020
Version/Revision Number	V.7.

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Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by Board**
V5.0	All. Sections rearranged so the document runs logically 1.1 Authority strengthened by showing by reference to oversight role and relationship with other statutory and assurance committees. Workforce Committee and Mortality Assurance and Clinical Improvement Committee added 1.2 Removal of *NHS Litigation Authority* and replace with *NHS Resolution*. 1.3 Remove *Whistleblowing* and replace with *Freedom to Speak Up* 1.4 Reference to CEO being called by the Committee if it wishes and certainly to present the *Annual Governance Statement* at year end 1.5 Added review of performance and effectiveness twice annually-at mid-year and end of the year	2017	2017
V6.0	2.1 Added Remuneration and Nominations Committee and Charitable Funds Committee 2.2 Diagram 1 updated to remove MACIC which is subsumed to QSC 2.3 Removal of *Mortality Assurance and Clinical Improvement Committee*	2018	2018
V7.0	3.1 Added new governance structure showing reporting arrangements 3.2 (c) Showing reports received from Risk and Compliance Group 3.3 (e) Added report relating to fitness to remain registered with the CQC as recommended by the Audit & Risk Committee Handbook 3.4 (f) Added receipt of Sustainability & Transformation Partnership Dashboard as recommended by the Audit & Risk Committee Handbook 3.5 (g) Added receipt of Quarterly Clinical Audit Progress Report as recommended by the Audit & Risk Committee Handbook 3.6 (h) Changed *Secretary of State for Health* to *Secretary of State for Health and Social Care* and changed Counter Fraud to Anti-Fraud 3.7 External Audit (h) Changed *Those Charged with Governance* to *Audit Completion Report*	2019	2019

V7.1	Added new governance structure showing reporting arrangements	2019	2019
V7.2	• Added 'Risk' to Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure • Added at 2.2 (j) ' Claims & Litigation Activities' • Updated membership to read 4 NEDs	2019	2019
V.8.0	• Removed 'Risk' to Committee name in narrative and governance structure • Amended to ensure template is consistent with all other Committees • Removed Risk and Compliance Group from Subgroup as it now reports to Quality and Safety Committee • Replaced reference to Company Secretary to reflect change in title to Associate Director of Corporate Governance	July 2020	Sep 2020

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Terms of Reference

1. Authority

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Audit Committee (the Committee) to carry out the duties set out at Clause 6 of these Terms of Reference. The Committee is a statutory committee of the Board and has no executive powers, other than those limited to these Terms of Reference.

1.2 The Audit Committee provides an 'oversight' role on behalf of the Board, reviewing the adequacy and effectiveness of controls. It is supported by the Quality and Safety Committee, Finance and Performance and Investment Committee, Workforce Committee (assurance committees), Remuneration and Nominations Committee and Charitable Funds Committee (statutory committees) which carry out their duties in reviewing systems of control and governance in relation to all matters of clinical quality and safety, financial control and investment and workforce and organisational development. See **Diagram 1.**

1.3 The Committee has the delegated authority to:

- Investigate any activity within its Terms of Reference. It can request information, reports, and assurances from any employee in relation to those areas within these Terms of Reference and all employees are directed to co-operate with any request made by the Committee.

- Obtain within the limits set out in the Trust's *Scheme of Delegation*, outside legal or other independent professional advice on any matter within its terms of reference and to secure the attendance of external persons with relevant experience and expertise if it considers this necessary

1.4 The Committee operates within the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

2 Purpose and Duties

The Committee is established to:

2.1 Critically review governance and assurance processes on which the Board places reliance. In particular, this requires the Audit Committee to understand and scrutinise the Trust's overarching framework of governance, risk and control. Its role is to satisfy itself that the same level of scrutiny and independent audit over controls and assurances is applied across all of the Trust's activities. These should be set out in an Annual Business Cycle.

2.2 Maintain oversight and provide assurance to the Board with regards to the integrity of the Trust's financial statements and reporting of financial performance.

2.3 Review the effectiveness of the Trust's internal and external audit function

2.4 Report to the Board of Directors on the discharge of its responsibilities as a Committee

2.5 In order to achieve its purpose the duties of the Committee are:

Governance, risk management and internal control:

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular the Committee will review the adequacy and effectiveness of:

a) All risk and control related disclosure statements (in particular the *Annual Governance Statement*), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board.
b) The underlying assurance processes that indicate the degree of achievement of corporate objectives, for example progress reports against delivery of the Annual Plan, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
c) The Committee will receive quarterly reports from the Risk and Compliance Group and an Annual Report
d) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
e) Fitness to remain registered with the Care Quality Commission
f) Receive the Sustainability & Transformation Partnership Dashboard
g) Clinical Audit through the Annual Report and and bi-annual Progress Report
h) The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State for Health and Social Care's Directions and as required by NHS Anti-fraud Authority (formerly NHS Protect).
i) Review the Trust's Losses and Special Payments report twice per annum.
j) The Claims & Litigation activities.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, including the Chairs of the Board Committees, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach the Committee will have effective relationships with other key committees (see 1.1 above) so that it understands processes and linkages. However, these other Committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Board. This will be achieved by:

a) Consideration of the provision of internal audit service, the cost of the audit and any questions of resignation and dismissal.
b) Review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
c) Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources.
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
e) Monitor the effectiveness of internal audit and carry out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
b) Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan
c) Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
d) Review of all external audit reports, including the Audit Completion Report, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
e) Ensuring that there is a clear policy in place for the engagement of external auditors to supply non audit services.

Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality and Safety Committee and, Finance, Performance and Investment Committee. This will be achieved by the consideration of minutes and Assure, Alert, Advise (AAAs) reports submitted from the aforementioned Committees and through common membership.

In reviewing issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the Quality and Safety Committee which has oversight of the clinical audit function that adequate arrangements are in place for undertaking clinical audits and implementing the learning from those reviews.

The Committee will also review the Trust's Losses and Special Payments report twice per annum.

Anti- Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, corruption and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

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

a) The wording in the *Annual Governance Statement* and other disclosures relevant to the terms of reference of the Committee.

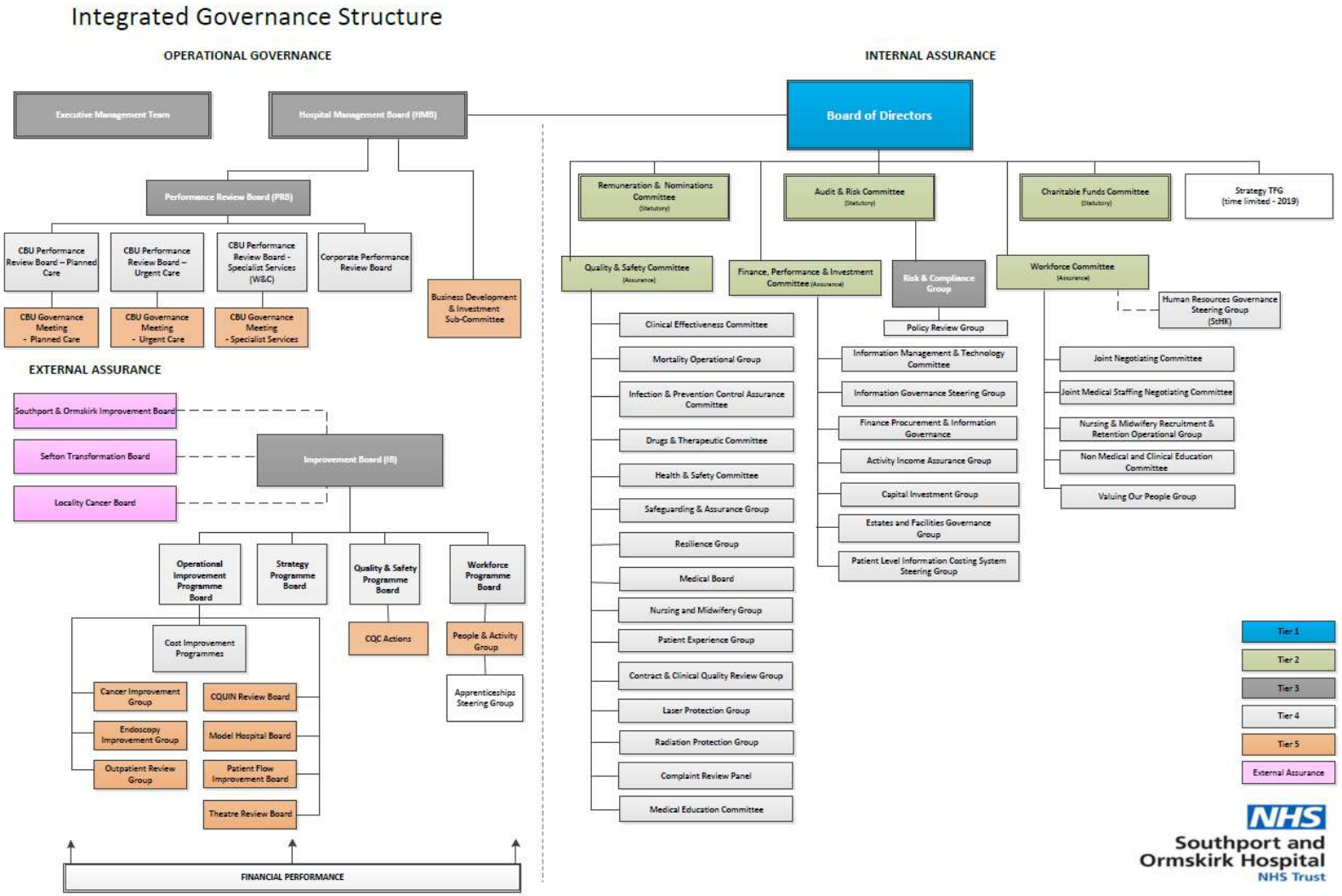
b) Changes in, and compliance with, accounting policies, practices and estimation techniques.
c) Unadjusted mis-statements in the financial statements.
d) Significant judgements in preparation of the financial statements.
e) Significant adjustments resulting from the audit.
f) Letters of representation.
g) Explanations for significant variances.

Freedom to Speak Up

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Southport and Ormskirk Hospital NHS Trust

Diagram 1. The relationship between the Audit Committee, the Board and other Trust committees.



3 Reporting

3.1 The minutes of Audit Committee meetings shall be formally recorded and submitted to the Trust Board**.** The Chair of the Committee shall produce a highlight report Alert, Advise and Assurance (AAAs) to draw the attention of the Trust Board to any issues that require disclosure to the full Board or require executive action.

4 Monitoring Compliance

4.1 Meetings of the Committee shall be conducted in accordance with the provisions of the *Standing Orders, Scheme of Reservation and Delegation* and Standing Financial Instructions approved by the Trust Board.

5 Membership

5.1 The membership of the Committee shall be comprised of four Non-Executive Directors (NEDs).

5.2 One of the members shall be appointed as Chair of the Committee by the Trust Board. In the absence of the Committee Chair, the remaining members shall elect amongst themselves a chair of the meeting.

5.3 The Committee shall be appointed by the Trust Board from amongst its independent non-executive directors and shall consist of not less than three members one of whom shall have relevant recent financial experience. The Chairman of the Trust may not be a member of the Audit Committee.

5.4 Only members of the committee have the right to attend committee meetings and have a single vote for any decisions to be taken by the committee.

6 Attendance

6.1 In addition, other senior specialist officers may attend from time to time to provide specialist advice and support.

6.2 The following persons shall be expected to normally be in attendance at meetings of the committee:

- Director of Finance
- Director of Nursing, Midwifery and Therapies
- Associate Director of Corporate Governance
- Internal Audit representative(s) including Anti- Fraud Specialist

- External Audit representative (s)

6.3 The Chief Executive may be called by the Committee at any time and certainly to present the Annual Governance Statement when the Annual Report and Accounts are reviewed at the end of the year (usually May).

Other members of the Executive Management Team can be requested to attend, particularly when the Committee is discussing areas of risk or operation that fall within their directorate responsibility.

The Associate Director of Corporate Governance shall be the secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.

The Committee shall also meet with the auditors at least once a year or on request of the Chair of the Committee, without management being present; to discuss their remit and raise any issues arising from the Trust's. In addition the Lead Partner of external audit shall be given the right of direct access to the Chair of the Committee and to the Committee members.

7 Quorum

7.1 A quorum for the Committee shall be two members. In order for the decisions of the committee to be valid the meeting must be quorate.

7.2 Members should normally attend meetings, and it is expected that members will attend a minimum of 75% of meetings held per annum.

7.3 Should a member not be able to attend a Committee meeting, apologies in advance must be provided to the Chair. Deputising arrangements must be agreed by the Chair prior to the meeting and any formal acting up status will be recorded in the minutes.

8 Frequency

8.1 The Committee shall meet not less than four times per year; a schedule of pre-arranged meetings will be distributed to all members on an annual basis along with a proposed annual work plan.

8.2 The Board, Accountable Officer (CEO), Chair of the Committee, may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

8.3 The Committee will report to the Board at least annually on its work in support of the *Annual Governance Statement*, specifically commenting on:

- the fitness for purpose of the Assurance Framework
- the completeness and 'embeddedness' of risk management in the organisation
- the integration of governance arrangements
- the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- the robustness of the processes behind the Quality Accounts.

The Annual Report will also describe how the Committee has fulfilled its duties as set out in the terms of reference including progress against its work plan, membership attendance, and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The Committee will develop an annual business cycle (work plan) mapping out how the Committee will fulfil its delegated duties.

9 Conduct of Meetings

9.1 The agenda and supporting papers will be distributed no less than 4 days in advance of the meeting. Authors of papers must use the required template as set out in the Standard Operating Procedure. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the Committee's Chair (or nominated Deputy).

9.2 The Committee will be supported by the Director of Finance and Associate Director of Corporate Governance, whose duties in this respect will include:

- Agreement of the agenda with the Chair and attendees
- Advising the Chair on pertinent issues/areas of interests/policy development
- Helping the Chair prepare reports to the Board
- Enabling the development and training of Committee members
- Facilitating the Committee's review of its own performance and effectiveness
- Facilitating the review of the effectiveness of internal and external audit

9.3 The Personal Assistant to the Associate Director of Corporate Governance shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers in good time
- Keep a record of matters arising and issues to be carried forward

9.4 Minutes of the meetings and action log will be circulated promptly to all members as soon as reasonably practical. Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues. Committee members may question the presenter.

Southport and Ormskirk Hospital NHS Trust

10 Reviewing Terms of Reference

10.1 The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Trust Board**.**

11 Review of Performance and Effectiveness

11.1 The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by Audit Committee	15 July 2020
Ratified by Board of Directors:	*2 September 2021*
Date for next review:	July 2021

Southport and Ormskirk Hospital NHS Trust

Charitable Funds Committee

Terms of Reference Document Control Sheet

MEETING	**Charitable Funds Committee**
ESTABLISHED BY/REPORTING TO:	Board of Directors
REVIEWER	Sharon Katema – Associate Director of Corporate Governance
REVIEW	July 2020
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED FORUMS/ COMMITTEES/GROUPS	Board of Directors Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Audit Committee Workforce Committee Hospital Management Board

Document Control	
Document Name	Charitable Funds Committee ToR – July 20
File Name	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\Charitable Funds Committee ToR – July 20
Version/Revision Number	V3.0

Southport and Ormskirk Hospital NHS Trust

Version Control Document		
Version Ref	**Amendment**	**Date Approved**
V2.0	1.1 Authority strengthened by showing by reference to oversight role and relationship with other statutory and assurance committees. Workforce Committee and Mortality Assurance and Clinical Improvement Committee added 1.2 Membership updated to read the members of the board as trustees of the fund are members of the committee. Add that the Company Secretary and Deputy Financial Accountant should be in attendance 1.3. Added that there should be a minimum of five members to form a quorum of which three must be NEDs 1.4 Added that the committee should undertake a review of its performance and effectiveness at least twice annually 1.5 Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. Added 'and Safety' to Quality Committee; added Remuneration & Nominations Committee and Audit & Risk Committee.	2017
V2.1	Added new governance structure showing reporting arrangements	2019
V2.2	• Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure	2019
V.3.0	• Removed Risk from any reference to Audit Committee • Added Charitable Funds Manager to the membership	2020

Southport and Ormskirk Hospital NHS Trust

Charitable Funds Committee

Terms of Reference

1. Authority

1.1. Southport & Ormskirk Hospital NHS Trust is appointed as the sole Corporate Trustee of The Southport & Ormskirk NHS Trust Charitable Fund (Charity No 1049227). The Board of Directors has responsibility for ensuring that the Trust discharges its responsibilities as Corporate Trustee. See **Diagram 1**.

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

1.3. The Charitable Funds Committee has the delegated authority to:

a) seek any information it requires from any employee of the Trust in order to perform its duties as set out below
b) obtain, within the limits set out in the Trust's *Scheme of Delegation*, outside professional advice on any matter within its terms of reference
c) call any employee to be questioned at a meeting of the committee as and when required.

1.4. Approved minutes of the committee are circulated to the Board for information at the first formal Board meeting following approval. The Chair of the Committee escalates items to the Board as appropriate.

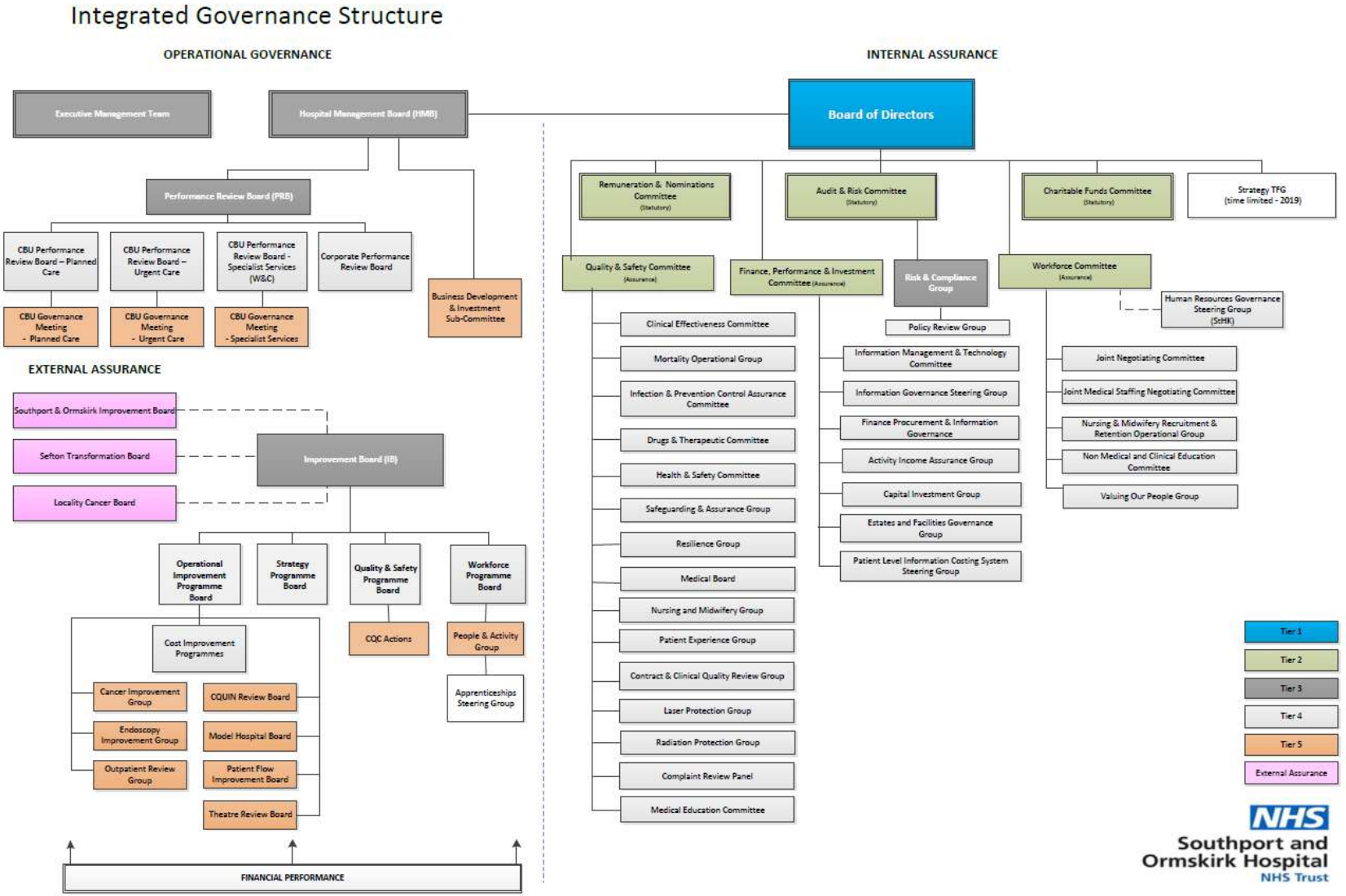
1.5. The committee operates within the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation & Delegation.

2. Purpose

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

Southport and Ormskirk Hospital NHS Trust

Diagram 1. The relationship between the Charitable Funds Committee, the Board and other Trust's Committees.



3. Principal Duties

In order to achieve its purpose the Committee will:

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

4. Constitution

4.1. **Chair**

The Trust Chairman shall chair the committee. In the absence of the Chair the Trust's Vice Chair (if there is one) will chair the meeting; if both the Chair and Vice Chair are absent the Trustees will make a decision in advance of the meeting as to whom among the Non-Executive Directors will chair that particular meeting.

4.2. **Membership**

The following will be members of the committee:

- All members of the Board of Directors

In attendance:

- Associate Director of Corporate Governance
- Assistant Director of Finance
- Deputy Financial Accountant
- Charitable Funds Manager

4.3. **Only members of the committee have the right to attend committee meetings and have a single vote for any decisions to be taken by the committee**

4.4. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.5. Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

4.6. An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

4.7. All members are required to attend at least 75% of meetings held.

5. Quorum

5.1 A quorum will be no less than four (4) members, two of whom must be NEDs and the Director of Finance or a deputy nominated by him. In order for the decisions of the committee to be valid the meeting must be quorate.

5.2 If a decision is needed between meetings a Virtual meeting may be convened but the decision made at this meeting must be ratified by the next full meeting of the Committee.

6. Frequency of meetings

6.1 The Committee will meet as required but no less than two times a year.

7 Organisation

7.1 **T**he minutes of the Charitable Funds Committee meetings shall be formally submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.2 The Director of Finance will prepare the Annual Report and Accounts of the charity in line with the Charity Commission requirements, which shall be received by the Charitable Funds Committee for consideration before submission to the Board of Directors as Corporate Trustee for approval.

7.3 The PA to the Director of Finance shall provide secretarial support to the committee. The agenda for the meeting shall be drawn up with the Chair of the committee. The agenda and papers for the meeting shall be distributed at least 7 days in advance of the meeting.

8 Review of Terms of Reference

8.1 These Terms of Reference shall be reviewed annually or in light of any changes in practice or legislation.

Southport and Ormskirk Hospital NHS Trust

9 **Performance and Effectiveness**

9.1 The Committee shall undertake at least once annually a review of its effectiveness and performance and report its outcome and any associated action plan to the Board as Corporate Trustee for approval

Approved by Charitable Funds Committee	**August** 2020
Ratified by Board:	*2 September 2020*
Date for review:	[July 2021]

Southport and Ormskirk Hospital NHS Trust

Hospital Management Board

Terms of Reference Document Control Sheet

MEETING	**Hospital Management Board**
ESTABLISHED BY / REPORTING TO:	Board of Directors
REVIEWER	Sharon Katema – Associate Director of Corporate Governance
REVIEW	July 2020
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED FORUMS /COMMITTEES/GROUPS	Board of Directors Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Audit Committee Workforce Committee Charitable Funds Committee

Document Control	
Document Name	Hospital Management Board ToR – July 20
File Name	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\ Hospital Management Board ToR - July20
Version/Revision Number	V2.0

Southport and Ormskirk Hospital NHS Trust

Version Control Document		
Version Ref	Amendment	Date Approved
V1.1	• Added 'Risk' to **Audit** Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure	June 2019
V.2	• Removed Risk to Audit Committee name • Conducted a review of current ToRs to reflect the change in function of HMB	July 2020

Southport and Ormskirk Hospital NHS Trust

HOSPITAL MANAGEMENT BOARD

Terms of Reference

1. Authority

The Board hereby resolves to establish a Committee of the Trust to be known as the Hospital Management Board (HMB), hereafter referred to within this document as the *HMB.*

The HMB is authorised by the Board of Directors to investigate any activity within its terms of Reference.

The HMB has been established in accordance with the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation

The HMB is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The HMB may not delegate executive powers and remains accountable for the work of any such group. Any sub-groups or working groups will report directly to HMB who will oversee their work.

2. Purpose

The key deliverables:

- The Trusts Strategic Plan and Annual Plan
- Cost Improvement Plan (CIP) Programme
- The Trusts transformation programme to ensure improvement of quality, experience, outcomes and financial efficiencies
- A rigorous approach to adopting and embedding Quality Improvement (QI)
- Assurance of Clinical leadership to Transformation
- Assurance the patient is at the centre of patient redesign
- Evaluation of the transformation programme, ensuring benefits realisation
- Ensuring that all Transformation Programmes have Executive oversight and are managed against a programme plan.
- The HMB will oversee the development of the Trust Annual Plan so that when it is presented to Board of Directors for approval it is robust in terms of its objectives, performance measures, investment priorities and affordability. The HMB plays a key role in developing the overall strategy of the Trust.
- It is also the formal route to support the Chief Executive in effectively discharging responsibilities as Accounting Officer.

3. Responsibilities

The HMB has delegated powers from the Board of Directors to monitor the transformation plan and cost improvement programme. This relates to assurance both that initiatives that have been implemented are being achieved in line with plan and that initiatives proposed to be implemented have robust and deliverable plans in place. In addition to monitoring progress, the Board will provide guidance on priorities and will have responsibility for providing all the necessary CBU support to ensure the programme succeeds.

In particular HMB will ensure there is a rigorous approach to adopting and embedding QI / Transformation processes across the organisation including:

- Developing a clear strategic intent for QI Transformation including the organisational approach to QI
- Leadership for QI that is visible at different levels of the organisation
- A systematic framework to build improvement skills at all levels
- Patients being at the centre of QI. To deliver this, patients must be involved and enabled as true and equal partners
- Systems thinking is applied in QI activity, which results in improvement beyond organisational or functional boundaries, with impact from improvement activity seen across health, social care and wider systems
- Building a culture of improvement at all levels, which is modelled by the senior team and engages clinical leaders and empowers and enables all staff to make effective and sustainable improvements.

4. Constitution

The Hospital Management Board (HMB) is established by Board of Directors in accordance with the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

The HMB shall draw to the attention of the Board any issues that require disclosure or require executive action through an Alert, Advise and Assure (AAAs) Highlight Report and minutes.

4.1 Chair

The HMB will be chaired by the Chief Executive

4.2 Membership

- Executive Management Team
- Associate Director of Corporate Governance / Company Secretary
- Head of Information Technology
- Associate Director of Strategy
- Associate Director of Estates and Facilities
- Head of Pharmacy
- Clinical Business Units Triumvirate:
  - -Associate Medical Directors of Clinical Business Units (CBUs)
  - -Assistant Directors of Clinical Business Units
  - -Heads of Nursing of Clinical Business Units
- Programme Director : Shaping Care Together

5. Quorum

A quorum will be no less than five members which must include at least two (2) Executive Directors and at least one (1) representative from each CBU.

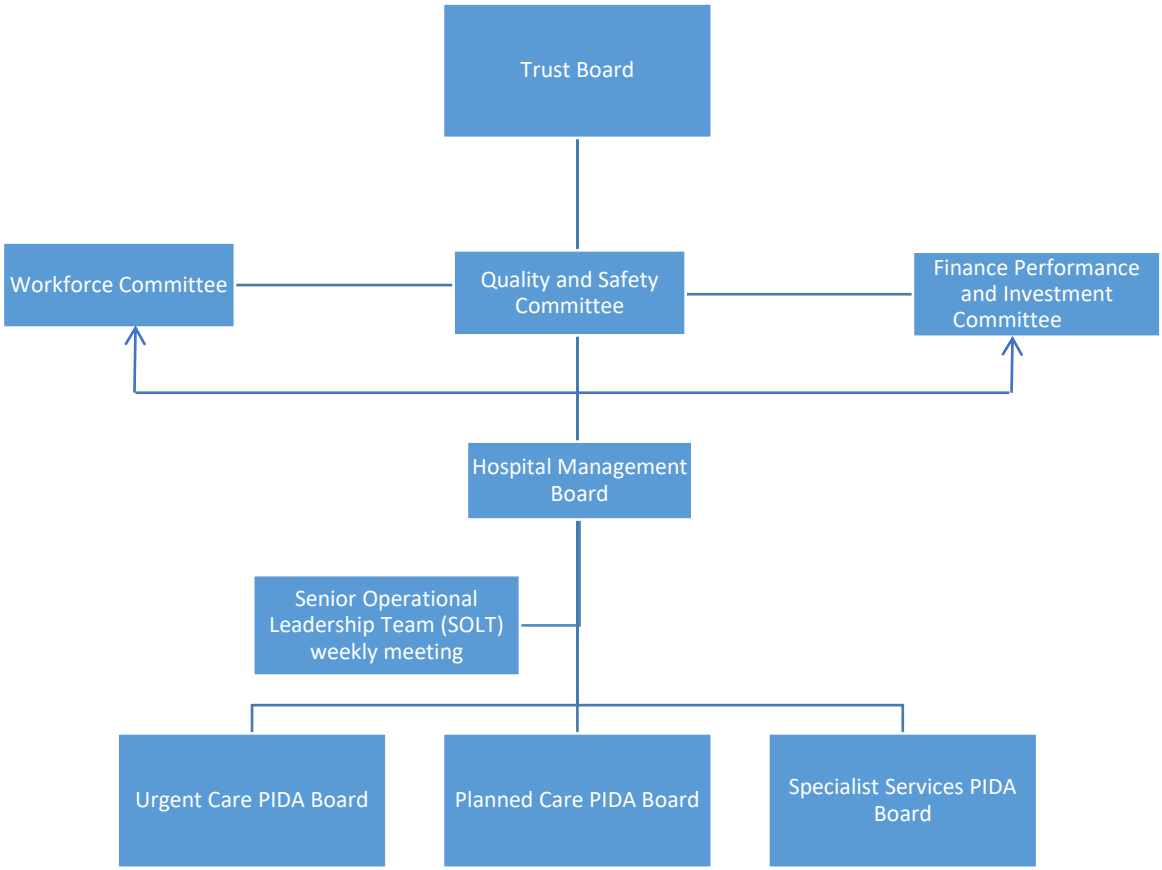
If a member is unable to attend a meeting, they can nominate a deputy (if an appropriate deputy is available) to attend the meeting in their place. The HMB may call upon any employee to attend the Board.

The HMB will meet no less than 10 times per year, usually once per calendar month.

6. Organisation and Reporting Arrangements

The minutes of HMB meetings shall be formally submitted to the Executive Team and the Board. The Chair of the Committee shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action via an Alert, Advise and Assure (AAAs) report and minutes.

The HMB will produce an annual work-plan/business cycle for the Board to approve at the beginning of each financial year, mapping out how it will fulfil its delegated duties.



7. Conduct of Meetings

The PA to the Chief Executive shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the meeting
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting.

The agenda for the meeting shall be drawn up by Associate Director of Corporate Governance in conjunction with the Chair (CEO) and in consultation with the Executive Team. Meetings are not open to members of the public.

Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

8. Monitoring of Performance and Effectiveness

The HMB will undertake an annual review of its performance and effectiveness against its work plan as set out in the Terms of Reference and the Trust's Annual Plan in order to evaluate the achievement of its duties. This review will be received by the Board of Directors.

9. Review of Terms of Reference

These Terms of Reference will be reviewed at least annually as part of the monitoring effectiveness process.

Southport and Ormskirk Hospital NHS Trust

Quality and Safety Committee

Terms of Reference Document Control Sheet

MEETING	Quality and Safety Committee
ESTABLISHED BY /REPORTING TO:	Board of Directors
Reviewer:	Sharon Katema, Associate Director of Corporate Governance
REVIEW:	August 2020
ASSOCIATED DOCUMENTS:	Standing Orders Scheme of Reservation and Delegation Quality Improvement Strategy Risk Management Strategy Corporate Risk Register Board Assurance Framework Safeguarding Policy Freedom to Speak Up/Raising Concerns Policy
RELATED COMMITTEES /GROUPS	Board of Directors Finance, Performance and Investment Committee Audit Committee Remuneration and Nominations Committee Charitable Funds Committee Workforce Committee Hospital Management Board **Sub Committees** Clinical Effectiveness Mortality Operational Group Safety Safeguarding Patient and Staff Experience Health & Safety Risk and Compliance Group

Document Control	
Document Name	Quality and Safety Committee - ToR Aug 20
File Name	**\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\Quality and Safety Committee ToR – Aug 20**
Version/Revision Number	**V4.0**

NHS
Southport and Ormskirk Hospital
NHS Trust

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by Board**
V2	1.1 Added authority and responsibility diagram 1.2 Purpose: Added four bullet points on purpose: 1.3 Replace *practical* with *practicable* *1.4 Replace Assistant Company Secretary taking minutes at committee* with *PA to Medical Director* 1.5 Added that the Committee should undertake a review of its performance and effectiveness at mid and year-end Added the Safeguarding and Freedom to Speak Up/Raising Concerns Policies	**Q&S Cttee 2017**	**2017**
V3.0	3.1 Front Page: Added the Mortality Operational Group and Charitable Funds Committee. Removed Mortality Assurance and Clinical Improvement Committee. Added Mortality Operational Group to Sub Committees. 3.2 Added Mortality Operational Group 3.4 Added Mortality Operational Group and its Principal Duties. 3.5 Membership updated	**2018**	**2018**
V3.1	Added new governance structure showing reporting arrangements	**2019**	**2019**
V3.2	Removed the following from the membership: • Chief Operating Officer • Director of HR & OD • Director of Strategy		**April 2019**
V3.3	• Edited 'Extreme' to 'Corporate' Risk Register • Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure 4.3 Updated membership to include a NED with recent financial experience 4.4 Added that a rotating NED will count towards a Quorum if needed		**June 2019**
V.4	• Added Risk and Compliance Group • Removed 'Risk' from Audit & Risk Committee name •	**August 2020**	

NHS
Southport and Ormskirk Hospital
NHS Trust

Quality & Safety Committee

Terms of Reference

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Quality & Safety Committee, hereafter referred to within this document as the *Committee.* See Diagram 1.

1.2 The Committee has no executive powers, other than those limited to these Terms of Reference

1.3 The Committee has the delegated authority to:

a) Seek any information it requires and/or call any employee of the Trust to a meeting of the Committee in order to perform its duties as set out below.
b) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.4 The Committee operates within the Trust's Standing Orders and Standing Financial Instructions.

1.5 The Committee operates at a strategic level as the executives are responsible for the day to day operational delivery and management.

1.6 Any changes to these Terms of Reference must be approved by the Trust Board

2. Purpose

2.1 The overall responsibility for clinical quality risk management, patient safety and quality of care delivery lies with the Trust Board; however, the Committee is established to provide the Board with assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on safety, quality, risk management, mortality and morbidity.

2.2 The Committee will triangulate patient safety, quality and risk issues with operational, financial and workforce performance addressing areas of concern or deteriorating performance as required.

2.3 In particular, the Committee will review the adequacy and effectiveness of the underlying assurance processes that support achievement of the corporate objectives and the management of principal risks, including:

- Board Assurance Framework
- Risk Register
- Clinical Audit Programme
- Policies and Procedures
- Freedom to Speak up arrangements

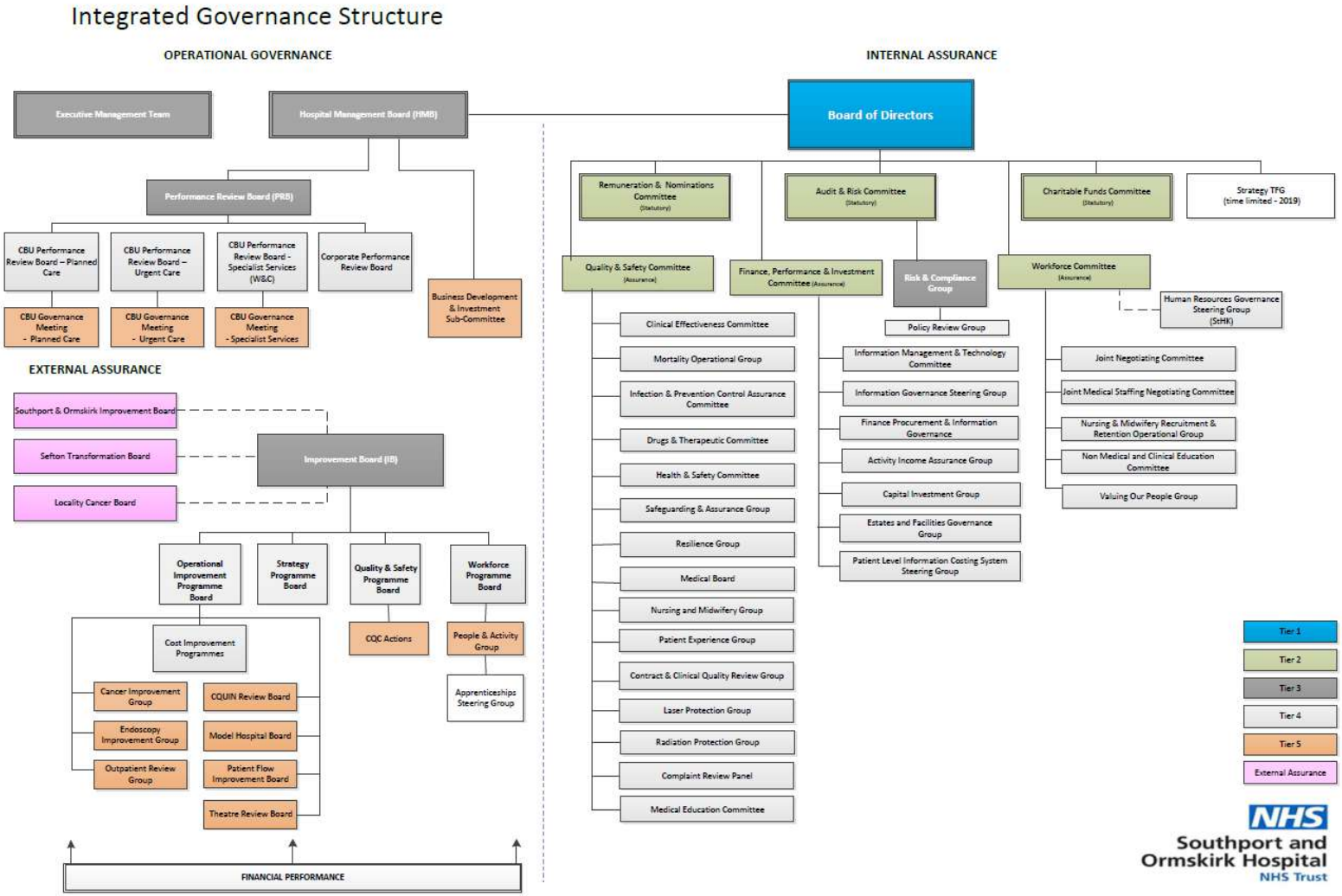


Diagram 1. The relationship between the Quality & Safety Committee, the Board and other Trust committees

3. Principal Duties

3.1 The duties of the Committee can be categorised as follows:

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

3.2 Overseeing the work of the following reporting sub-committees:

- Clinical Effectiveness Group
- Mortality Operational Group
- Health and Safety Group
- Safeguarding
- Patient and Staff Experience
- Risk and Compliance Group

3.3 **Clinical Effectiveness & Patient Safety**

a) Monitoring delivery of the priorities set out in the Quality Improvement Strategy, in particular those relating to mortality and the reduction of harm to patients.
b) Reviewing other key performance indicators in order to monitor and evaluate clinical quality and performance within the trust.
c) Reviewing the Quality Accounts and recommending for approval by the Board
d) Assessing the clinical and quality impact assessments of financial decisions within the Trust e.g. the impact of cost improvement programmes
e) Considering the resource implications for quality monitoring, improvement and risk control and advising the Board accordingly.
f) Receiving assurance that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and ensuring learning is embedded across the Trust.
g) Reviewing trends in complaints, serious incidents, claims and litigation and receive assurance that examples of good practice are disseminated across the Trust.
h) Overseeing compliance with the Essential Standards of Quality and Safety and ensuring sufficient evidence of compliance is available to the Board.
i) Ensuring that the Trust by gathering, analysing and using information effectively takes action to improve patient safety and creates a climate of continuous learning and improvement
j) Overseeing the development of a clinical audit plan and keeping implementation of the plan under review.

k) Making recommendations to the Audit & Risk Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.
l) Promoting within the Trust a culture of open and honest reporting and monitoring compliance against the CQC's Duty of candour requirement.

3.4 **Mortality Operational Group**

a) Mortality process and reviews.
b) 7 Day working.
c) Coding.
d) Clinical Pathways.
e) Reviewing other key performance indicators in order to monitor and evaluate mortality performance within the Trust.
f) Making recommendations to the Quality & Safety Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.

3.5 **Patient Experience**

Act upon the results of surveys relating to the patients' care experience in order to improve quality of experience across the Trust.

Ensure the effectiveness of the organisational arrangements for measuring and acting on feedback from service users.

3.6 **Safeguarding**

Ensuring that the Trust has robust arrangements in place to safeguard patients.

3.7 **Risk**

Ensuring the identification, management and control of clinical risk is robust and cohesive, taking action where necessary and alerting the Board to any areas of concern.

Ensuring that the Trust has robust resilience plans in place.

3.8 **Performance**

Review stretch targets as they relate to quality of care provision, effectiveness and safety and monitor achievement against performance forecasts.

4. Constitution

4.1 **Chair**

The minutes of Workforce Committee meetings shall be formally recorded and submitted to the Board of Directors The chair of the committee will be a Non-Executive Director. In the absence of the chair one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 **Membership**

The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* and shall consist of the following members:

- Three (3) independent Non-Executive Directors, at least one of whom shall have a clinical background
- Director of Nursing, Midwifery & Therapies
- Medical Director
- Associate Medical Director for Patient Safety

4.3 All Board Members may attend any Committee meeting.

4.4 The Associate Director of Corporate Governance is required to attend meetings of the Committee in a non-voting capacity

4.5 The following persons shall be expected to normally be in attendance at meeting:

- Deputy Director of Nursing
- Deputy/Associate Medical Directors
- Assistant Director of Integrated Governance
- Staff Side Representative
- Patient Representative

4.6 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.7 To ensure that the Non-Executive Directors have the majority vote only the Director of Nursing, Midwifery & Therapies, the Medical Director and the Chief Operating Officer will have a vote within the Quality & Safety Committee. The Chair of the Committee will have a casting vote.

4.8 All members are required to attend at least 75% of meetings held. Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

4.9 An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

5. Quorum

5.1 In order for the decisions of the Committee to be valid the meeting must be quorate. A quorum will be no less than three Members including two Non-Executive Directors (one of whom must be either the Chair of the Committee or the nominated Chair) and one Executive Director who must be either the Director of Nursing & Midwifery or the Medical Director.

5.2 In the event there are insufficient regular NED members, a rotating NED who is present will count towards the Quorum

6. Frequency of meetings

6.1 The Committee will meet no less than ten times a year, usually once a calendar month.

6.2 The Chair of the Committee may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

7. Organisation and Reporting Structure

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board of Directors**.**

7.2 The Chair of the Committee shall produce a Alert, Advise and Assurance (AAAs) highlight report to draw the attention of the Trust Board to any issues that require disclosure to the full Board or require executive action

7.3 The Committee will report to the Board at least annually on its work in support of the Quality Governance Framework self-certification and relevant Board Statements required by NHS Improvement and the Care Quality Commission.

7.4 The Committee will produce an annual work-plan/business cycle for the Board to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

8. Conduct of Meetings

8.1 The PA to the Medical Director (in their absence the PA to the Director of Nursing & Midwifery) shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

8.2 The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting.

8.3 The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Director of Nursing and Midwifery and Medical Director.

8.4 Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable. Meetings are not open to members of the public.

8.5 Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

9. Reviewing Terms of Reference

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

10. Review of Performance and effectiveness Review

The Committee shall also undertake a review of its performance and effectiveness at least once annually.

Approved by Quality & Safety Committee 25 August 2020

Ratified by Board of Directors: *2 September 2021*

Date for next review: July 2021

Southport and Ormskirk Hospital NHS Trust

Remuneration and Nominations Committee

Terms of Reference Document Control Sheet

MEETING	**Remuneration and Nominations Committee**
ESTABLISHED BY /REPORTING TO:	Trust Board
Reviewer	Sharon Katema, Associate Director of Corporate Governance
REVIEW	May 2020
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED FORUMS/ COMMITTEES/GROUPS	Board of Directors Quality and Safety Committee Finance, Performance and Investment Committee Remuneration & Nomination Committee Audit & Risk Committee Charitable Funds Committee Workforce Committee Hospital Management Board

Document Control	
Document Name	RemCom ToR Jun20
File Name	\\datamart1\Shared Files\Company Secretary Remuneration and Nominations Committee\Terms of Reference\ RemCom ToR Jun20
Version/Revision Number	4.0

Southport and Ormskirk Hospital NHS Trust

Version Control Document		
Version Ref	**Amendment**	**Date Approved**
V2.0	1.1 Authority strengthened by showing relationship with other statutory and assurance committees. 1.3 Added AAAs report to the board 1.4 Added that the committee should undertake a review of its performance and effectiveness at least twice annually	2017
V3.0	2.1 Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. Added 'and Safety' to Quality Committee; Remuneration & Nomination Committee and Charitable Funds Committee.	2018
V3.1	3.1 Added new governance structure showing reporting arrangements	2019
V3.2	• Added 'Risk' to Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure	2019
V4.0	• Amended references to Associate Director of HR to DoHR and OD	2020

Southport and Ormskirk Hospital NHS Trust

Remuneration and Nominations Committee

Terms of Reference

1 Authority

1.1 The Board has established a Committee of the Trust to be known as the Remuneration and Nominations Committee, hereafter referred to within this document as the *Committee.* **See Diagram 1.**

1.2 The Committee has the delegated authority from the Board to:

a) seek any information it requires from any employee of the Trust in order to perform its duties as set out below
b) obtain, within the limits set out in the Trust's *Scheme of Delegation*, outside professional advice on any matter within its terms of reference
c) call any employee to be questioned at a meeting of the committee as and when required.

1.3 Approved minutes of the Committee are to be circulated to the Board for information at the first formal Board meeting following approval. The Chair of the Committee shall provide an AAAs Highlight report on key issues to the Board at the Board meeting.

1.4 The Committee operates within the Trust's *Standing Orders* and *Standing Financial Instructions.*

1.5 The Committee will operate at a strategic level.

2 Purpose

2.1 The purpose of the Committee is to advise the Board on the appropriate remuneration and terms of service for Chief Executive and members of the Executive Management Team, ensuring that a formal, rigorous and transparent procedure for Board appointments is followed and consider Board succession planning.

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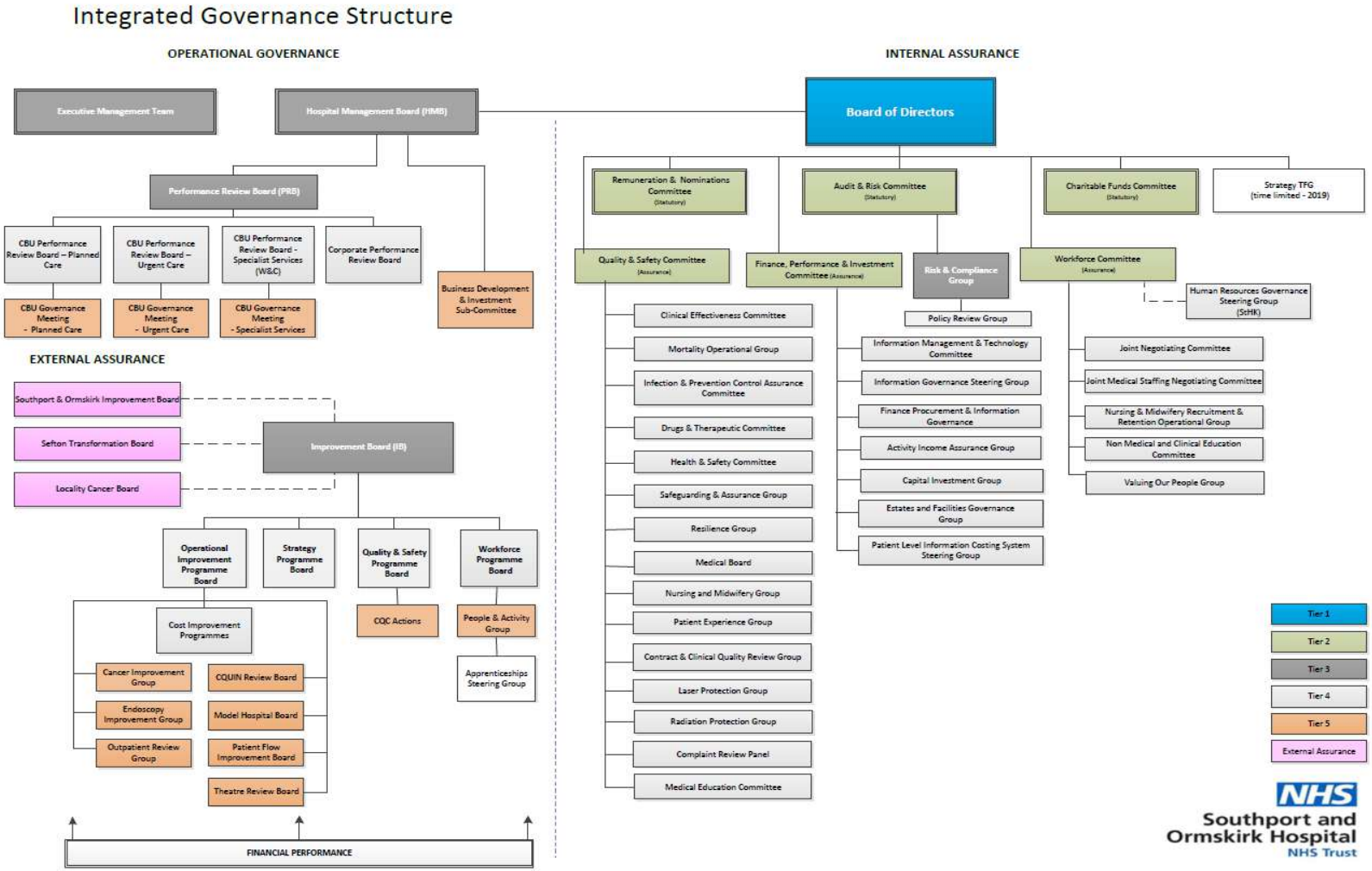

Diagram 1. The relationship between the Renumeration & Nominations Committee, the Board and other Trust committees.

3 Principal Duties

3.1 In order to meet its purpose the Committee will, under the following headings:

3.2 **Remuneration**

a) Determine the framework for the remuneration of the Chief Executive and members of the Executive Management Team including performance related elements, pensions and cars as well as arrangements for termination of employment and other contractual terms.
b) Take into consideration when determining performance related elements the performance of individual directors and senior managers
c) Oversee appropriate calculation and scrutiny of termination payments.

3.3 **Nomination**

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

4 Constitution

4.1 **Chair**

The Trust's Chair shall chair the Committee. In the absence of the Chair or deputy chair, another Non-Executive Director member will be nominated in advance, to chair the meeting.

4.2 **Membership**

The following will be members of the Committee:

- All Non-Executive Directors, including the Chair of the Trust, all of whom should be considered independent

4.3 In attendance at the invitation of the Committee for all or part of any meeting will be:

- Chief Executive
- Director of Human Resources & Organisational Development or equivalent
- Associate Director of Corporate Governance

The Chief Executive and Director of HR & OD may not be present when the Committee is considering their remuneration.

Only members of the committee have the right to attend Committee meetings and have a single vote regarding any decisions to be taken by the Committee.

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5 Quorum

5.1 A quorum will be no less than three Members.

5.2 In order for the decisions of the Committee to be valid the meeting must be quorate.

6 Frequency of meetings

6.1 The Committee will meet as required but no less than twice a year.

7 Organisation and Reporting to the Board

7.1 The minutes of Remuneration and Nominations Committee meetings shall be formally submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.2 The Associate Director of Corporate Governance shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

7.3 The agenda and papers for the meeting shall be distributed no less than 4 days in advance of the meeting.

7.4 The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Director of Human Resources and Associate Director of Corporate Governance. Meetings are not open to members of the public.

8 Review

8.1 The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

9 Performance and Effectiveness

9.1 The Committee shall undertake an annual review of its performance and effectiveness.

Approved by Remuneration Committe: **May 2020**

Ratified by Board: *2 September 2020*

Date for review: [July 2021]

Southport and Ormskirk Hospital NHS Trust

Workforce Committee

Terms of Reference Document Control Sheet

MEETING	Workforce Committee
ESTABLISHED BY /REPORTING TO:	Board of Directors
Reviewer:	Sharon Katema, Associate Director of Corporate Governance
REVIEW:	August 2020
ASSOCIATED DOCUMENTS:	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED COMMITTEES /GROUPS	Board of Directors Finance, Performance and Investment Committee Audit Committee Remuneration and Nominations Committee Quality and Safety Committee Charitable Funds Committee Hospital Management Board **Sub Committees** Joint Negotiating Committee Joint Medical Staffing Negotiating Committee Valuing Our People Nursing, Midwifery and Therapies Group Nursing and Midwifery Recruitment & Retention Operational Group Non-Medical Clinical Education Group Workforce Improvement Group Medical Workforce Taskforce

Document Control	
Document Name:	Workforce Committee ToR - July 2020
File Name:	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\Workforce Committee ToR-Aug20
Version/Revision Number:	V7.0

Southport and Ormskirk Hospital NHS Trust

Version Control Document			
Version Ref	**Amendment**	**Committee review and approval**	**Ratified by Board**
V5.0	Added accountability and responsibility diagram 1.2 Differentiated between membership and those in attendance Membership edited 1.3 Added a quorum 1.4 Added review of Terms of Reference and the Committee's performance and effectiveness Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. 1.5 Added 'and Safety' to Quality Committee; added Remuneration & Nomination Committee and Charitable Funds Committee.	Workforce Cttee 2017	**2017**
V6.0	**RELATED FORUMS/COMMITTEES/GROUPS** Removed: • Organisation Development • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) Diagram 1 revised to reflect above changes **Other functions of the Workforce Committee** Removed: • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) **Membership** Replaced Assistant Director of Organisational Development with Head of Education & Training **Groups reporting to Workforce Committee** Removed: • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC	Workforce Cttee 2018	**2018**
V6.1	Added new governance structure showing reporting arrangements	Workforce Cttee 2019	**2019**
V6.2	4.Removed Director of Nursing, Midwifery & Therapies Added Chief Operating Officer as substantive member from membership 4. Update title of Associate Director of HR to Director of	Workforce Cttee 2019	**2019**

	HR & OD		
V6.3	• Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure • Added Deputy CEO to membership • Removed from Section 8 Health & Wellbeing Assurance, Medical Education Committee Added under Section 8 : • Valuing our People • HR Governance Assurance • Non-Medical Clinical Education Group • Nursing & Midwifery Recruitment and Retention Operational Group • Nursing & Midwifery Group	June 2019	**July 2019**
V7.0	Amended to: Used new, revised template. Under 'Sub-Committees' Remove: • HR Contract with St Helens & Knowsley NHS Trust • Human Resources Add: • Workforce Improvement Group • Medical Workforce Taskforce Under section 3.2: Add: • Agency compliance • Rostering levels of attainment. • agenda for change job evaluation Remove: CQUIN Add 3.3: Volunteer / Community Strategy Amend 3.5: The Workforce Committee is able to approve policies for final approval and ratification from the Policy Development Group. Policies reporting to the Committee should be monitored on an annual basis. Amended under section 4: • Non-Medical Clinical Education Group • Joint Medical Staff Negotiating Committee Section 4: Amended: • Staff Side Lead • Head of Education, Training and Organisational Development • Associate Director of Health and Wellbeing • 4.2 - Replace Associate Director of Nursing – Workforce with Director of Nursing, Midwifery and Therapies / Deputy Director of Nursing, Midwifery and Therapies. • 4.5 - Add Associate Director of Nursing Workforce.	July 2020	September 2020

	• Remove Assistant Director of HR Governance and Quality from 4.2 and replace with Deputy Director of Human Resources & Organisational Development. Assistant Director of HR Governance and Quality to 4.5 Under section 4.5: Add: • Volunteer Manager • Head of Resourcing • Associate Directors of Operations (on rotation) Remove: • Estates and Facilities Management Representative • Removed under section 8.7: • Education and Training Assurance Group • Health & Safety • HR Policy Development Sub Group		

Southport and Ormskirk Hospital NHS Trust

Workforce Committee
Terms of Reference

1. Authority

1.1 The Workforce Committee is constituted as a standing committee of Southport and Ormskirk Hospital NHS Trust's Board of Directors. Its constitution and terms of reference shall be as set out below.

1.2 The Workforce Committee operates within the Trust Standing Orders and Standing Financial Instructions.

1.3 The Workforce Committee has the delegated authority to obtain, within the limits set out in the Trust Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.4 The Workforce Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.6 Any changes to these Terms of Reference must be approved by the Trust Board

2. Purpose

The Committee is established to:

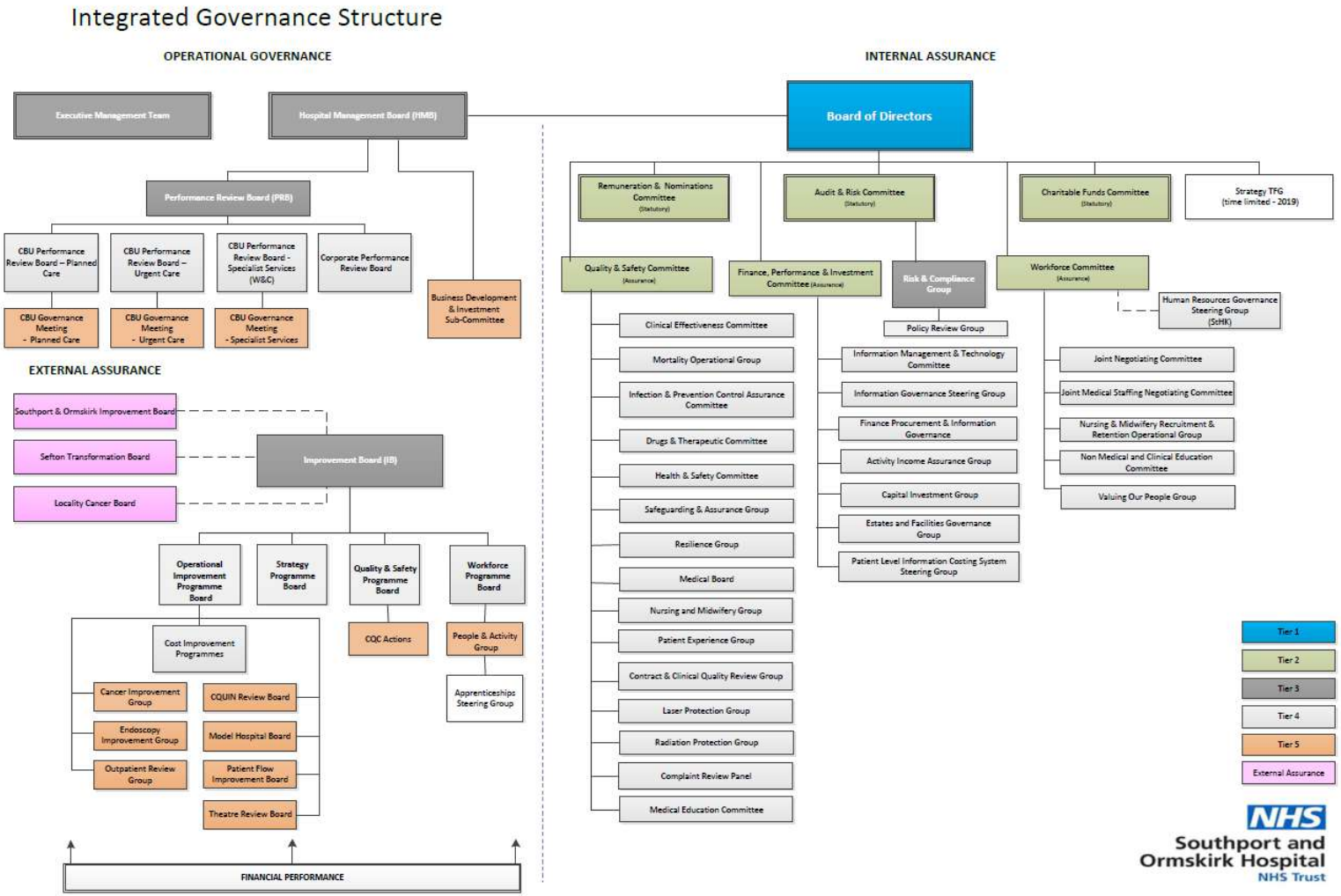
2.1 Ensure that the Trust complies with externally set standards and establish, monitor and review content and methods of providing assurance to the Board in relation to the delivery of the Trust's Workforce and Organisation Development Strategy.

2.2 Ensure that the Trust's cultural identity, values and behaviours are aligned to the delivery of corporate objectives and compliance with legislation.

2.3 Ensure that the Trust's workforce has the capacity and capability to deliver the Trust's objectives through effective leadership and development, workforce planning and organisation development.

Southport and Ormskirk Hospital NHS Trust

Diagram 1: The relationship between the Workforce Committee, the Board and other Trust committees



Southport and Ormskirk Hospital NHS Trust

3. Principal Duties

3.1 In order to achieve its purpose and obtain the necessary assurance, the Workforce Committee will:

- Review delivery of the Trust's Workforce and Organisation Development Strategy and ensure that the performance management of the Trust is aligned with the Strategy.

- Review workforce performance data, quality indicators, and action plans to deliver improved performance covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place
- Monitor and evaluate compliance with public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics.

- Monitor the effectiveness of staff engagement processes. Oversee the development of the cultural identity, values and behaviours of the Trust, seeking assurance on the alignment with the delivery of workforce improvements.

- Review evidence relating to external standards, including NHS Resolution (NHSR), Safe, Effective, Quality Occupational Health Service (SEQOHS), NHS Employers Guidance and CQC standards, raising any concerns regarding non-compliance in a timely manner and focusing on outcomes and improvements to the quality of patient and staff experience

- Review and approving policies prior to ratification by the Policy Review Group

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

3.2 **Other functions of the Workforce Committee**

- Review and approve policies relating to workforce and inform the Trust Board

- Report feedback from the Board and ensure messages / issues are feeding back to care groups & department meetings

- Review any other issues regarding workforce that are raised at meeting

- Volunteers

Southport and Ormskirk Hospital NHS Trust

4. Constitution

4.1 **Chair**

The Chair of the committee will be a Non-Executive Director. In the absence of the chair one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 **Membership**

The Workforce Committee membership shall be appointed by the Board of Directors in accordance with the Standing Orders and shall consist of the following members:

- Chair (who must be an Non-Executive Director)
- Two (2) Non-Executive Directors
- Director of Human Resources & Organisational Development
- Deputy Director of Human Resources & Organisational Development (HR&OD)
- Deputy Chief Executive/Director of Strategy
- Director of Nursing, Midwifery and Therapies / Deputy Director of Nursing

4.3 All Board Members may attend any Committee meeting.

4.4 The Associate Director of Corporate Governance is required to attend meetings of the Committee in a non-voting capacity.

4.5 The following persons shall be expected to normally be in attendance at meetings of the committee:

- Head of Education, Training and Organisational Development
- Head of Human Resources
- Associate Director of Health and Wellbeing
- Head of Resourcing
- Associate Director of HR Governance and Quality
- Staff Side Lead
- BMA Representative
- Patient and Workforce Equality Lead
- Clinical Workforce Information Systems Manager
- Associate Director of Nursing – Workforce

4.6 Members are responsible for providing feedback to their CBU / Teams / committees they represent, and any agreed actions or recommendations as required.

4.7 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.8 An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member

Southport and Ormskirk Hospital NHS Trust

5. Quorum

5.1 The Committee will be deemed quorate when four members are present, of which two must be Non-Executive Directors and the Director of HR&OD.

5.2 A deputy must attend in the absence of the Director of HR&OD. Deputies for other Executive members should only attend if there are relevant agenda items.

5.3 Members (or an empowered deputy) are expected to attend a minimum of 70% of meetings. Chair or deputy will need to attend to ensure the meeting is quorate.

6. Frequency of Meetings

6.1 The Workforce Committee will meet a minimum of five times a year. The frequency of meetings will be reviewed annually.

7. Conduct of Meetings

7.1 The agenda and supporting papers will be distributed no less than 4 days in advance of the meeting. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the Committee's Chair (or nominated Deputy).

7.2 The Chair of the Committee shall produce a highlight report Alert, Advise and Assurance (AAAs) to draw the attention of the Trust Board to any issues that require disclosure to the full Board or require executive action.

7.3 The Director of HR & OD is responsible for setting the agenda, production and distribution of the minutes.

7.4 The Personal Assistant to the Director of HR & OD shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers in good time
- Keep a record of matters arising and issues to be carried forward

7.5 The Committee will report to the Board of Directors after each meeting through an assurance report which will provide an overview of the discussions at the meeting, details of any matters in respect of actions or improvements needed and decisions taken.

7.6 The Committee may escalate issues to the Executive Team for action and where required, reports will be made available to the Audit Committee on matters relating to this Committee.

7.7 The Groups reporting their AAA's to the Workforce Committee are:

- Joint Negotiating Committee
- Joint Medical Staffing Negotiating Committee

- Valuing our People
- Non-Medical Clinical Education Group
- Nursing & Midwifery Recruitment and Retention Operational Group
- Nursing, Midwifery & Therapies Group

These Groups will provide a minimum annual update report to the Committee

8. Reviewing Terms of Reference

8.1 The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Trust Board**.**

9. Review of Performance and Effectiveness

9.1 The Workforce Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by Workforce Committee 28 July 2020

Ratified by Board: *2 September 2020*

Date for review: [July 2021]

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 September 2020**
Agenda Item	**TB136/20**	**FOI Exempt**	**No**
Report Title	**Annual Resuscitation Report**		
Executive Lead	**Dr Hankin, Executive Medical Director**		
Lead Officer	**Angie Westwood, Acting Matron - Critical Care**		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide and update and assure the Board that the standards and outcome with respect to Cardiopulmonary resuscitation are within National Guidance.

Executive Summary

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. Its purpose is to promote local performance management through the provision of timely, validated comparative data to participating hospitals.

The Trust's latest NCAA Report outlines that:

- Cardiac arrest rate per thousand cases has plateaued.
- There are less arrests overall (45), numbers small for detailed statistical analysis.
- Most common days for arrest are Wed 8-8 and Sun 8-8 with most arrests are medical patients and non-shock able.
- Survival to discharge 13.3% down from previous report.
- Performance as per funnel plots remains in expected range.
- Much higher than average asystolic cardiac arrest, with expected poor outcome. Probably reflects patient demographic.

Recommendations

The Board is asked to receive the Annual Resuscitation Report.

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:**
Angie Westwood, Acting Matron – Critical Care	Dr Hankin, Executive Medical Director

National Cardiac Arrest Audit Report

Southport and Formby District General Hospital

01 April 2019 to 31 March 2020

(n = 45)

Date of report: 11/06/2020

ncaa@icnarc.org

Supported by Resuscitation Council (UK) and
Intensive Care National Audit & Research Centre (ICNARC)

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1. NCAA and your NCAA Report

About the National Cardiac Arrest Audit (NCAA)

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. NCAA is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre).

NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest.

Your hospital collects and enters data according to the NCAA data collection scope and dataset specification. The NCAA dataset was developed to ensure that all hospitals collect the same standardised data, so that accurate comparisons can be made.

NCAA is listed as a national clinical audit in the Department of Health's Quality Accounts. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report on in-hospital cardiac arrest procedures, 'Time to Intervene?' (2012), stated: "...Each Trust/hospital should collect structured information on patients who have a cardiac arrest. The National Cardiac Arrest Audit collects such data and hospitals are encouraged to participate...".

About your NCAA Report

The NCAA Report provides you with: an overview of the completeness of your data (for data your hospital has reported); analyses of activity and outcome; stratified analyses (drawing comparisons between your hospital and NCAA data); basic, anonymised comparative analyses (non-risk adjusted); and risk-adjusted comparative analyses, and identifies unexpected non-survivors.

The multivariable statistical risk model (developed upon NCAA achieving a sufficient sample size) and the risk-adjusted analyses allow fair comparisons of outcomes between participating hospitals to be made for the first time.

Cumulative NCAA Reports are produced quarterly (based on the financial year) and are available on the secure NCAA online system (for registered NCAA users at your hospital only):

- Q1 (April - end of June)
- Q1+Q2 (April - end of September)
- Q1+Q2+Q3 (April - end of December)
- Q1+Q2+Q3+Q4 (April - end of March)

2. How to use your NCAA Report

The NCAA Report marks the beginning of your local performance management/quality improvement process. We encourage you to disseminate the information in this Report to relevant staff in your department, as well as to colleagues in your hospital, Trust, etc. in order to promote wider discussion.

WHO to share your NCAA Report with:

- ✓ Resuscitation Committee and Chair, and Regional Resuscitation Officer Representative
- ✓ Resuscitation Team, staff in your department, and other staff involved with the NCAA data collection and validation process
- ✓ Resuscitation trainers/course director(s) - to use as a training and education tool (including Junior Doctor Resuscitation induction) and promote discussion
- ✓ Clinical teams at your hospital that feed into the patient journey e.g. nursing, outreach, general ward, critical care, surgical staff, Allied Health Professionals, etc.
- ✓ Senior managers (with responsibility for service development and business planning), doctors, nurses, clinical matrons, and clinical and quality improvement leads
- ✓ Relevant departments within your hospital/Trust e.g. audit, clinical audit, governance, management, critical care, medical emergency teams, medical directorates, etc.
- ✓ Trust Executives and Directors e.g. Trust Chief Executive, Medical Director, Director of Nursing, Non-Executive Director in your Trust responsible for Resuscitation Policy
- ✓ Relevant Boards e.g. Trust and Quality Board
- ✓ Relevant groups/committees at your hospital/Trust e.g. Patient group, Patient safety, Clinical Quality /Governance/Effectiveness group, Clinical Risk, Mortality, Deteriorating patient, etc.
- ✓ External stakeholders on a regional or national level e.g. CQC, NHSLA, C QUIN, CQEG, etc.

HOW to share/disseminate your NCAA Report:

- ✓ Raise at relevant meetings (monthly/quarterly/yearly), such as:
  - Resuscitation Team or Staff meetings;
  - Resuscitation Committee and Regional Resuscitation Officer meetings;
  - Management meetings; and
  - Service development and Business planning meetings.
- ✓ Why not add 'NCAA Report-review and learn' as a standing item on relevant meeting agendas?
- ✓ Provide a presentation/hold a seminar at relevant meetings (monthly/quarterly/yearly)
- ✓ Resuscitation Committee and Chair to share key results/quick reference summary section, locally
- ✓ Save NCAA Report electronically on your shared drive for colleagues to access
- ✓ Email NCAA Report/key results or quick reference summary section to colleagues
- ✓ Include key points/results from quick reference summary section in any local newsletters or intranet
- ✓ Display key results on your staff notice board or performance boards in common areas

WHAT to reflect upon in your NCAA Report:

- ✓ Consider the suggested questions at the beginning of each section, as a basis for your discussion
- ✓ Identify and discuss any areas of concern, areas for improvement, and training options
- ✓ Identify trends or any areas of interest (for further analysis)
- ✓ Agree targets for improvement for the next quarter and year (and put an action plan in place)
- ✓ Identify cardiac arrests attended by the team to review in greater detail
- ✓ Use your data to support any Root Cause Analysis (RCA)
- ✓ Discuss areas of success, identify reason, and feedback to relevant teams locally
- ✓ Collate any questions/feedback for the NCAA Team

While interpreting the data within your NCAA Report, it is important to consider the suggested questions for local use at the beginning of each section (within the shaded grey box). These questions can form the basis for local discussion/further investigation. Considering each question will help you to maximise the value of your NCAA Report in order to feed into your local performance management/quality improvement process.

The principles of quality improvement include:

- understanding the problem, focussing on what the data tell you;
- understanding the processes and systems within your hospital;
- analysing the demand, capacity and flows of the service;
- choosing the tools to bring about change, including leadership and clinical engagement, plus staff and patient participation; and
- evaluating and measuring the impact of a change

The brief checklist provided at the end of this Report outlines some suggested next steps in order to bring about the implementation of change.

A quick reference summary providing key analyses within the NCAA Report is available at the end of the Report.

Please note: If sharing or presenting NCAA results/data, you must acknowledge the scope of data collection, the period it relates to and how many team visit records it is based upon (sample size).

3. About the data in this Report

Scope of data collection

NCAA data are collected for any resuscitation event commencing in-hospital where an individual (excluding neonates) receives chest compression(s) and/or defibrillation and is attended by the hospital-based resuscitation team (or equivalent) in response to a 2222 call - these team visits are referred to, in this Report, as cardiac arrests attended by the team.

Data collection/validation method

Your data have been validated both at the point of entry onto the secure NCAA online data entry system and centrally at ICNARC. Data are checked for completeness and illogicalities.

Numbers this Report is based on

Reported numbers of admissions to your hospital, 2222 calls, cardiac arrests attended by the team and individuals covered by this Report are presented below.

Period	Total number of admissions to your hospitalˆ	Total number of 2222 calls solely for cardiac arrest	Total number of reported cardiac arrests attended by the team that met the scope of NCAA	Number of individuals
01/04/2019 - 31/03/2020	37,266	46	45	45

Note:
ˆTotal includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)

Suggested questions for local use

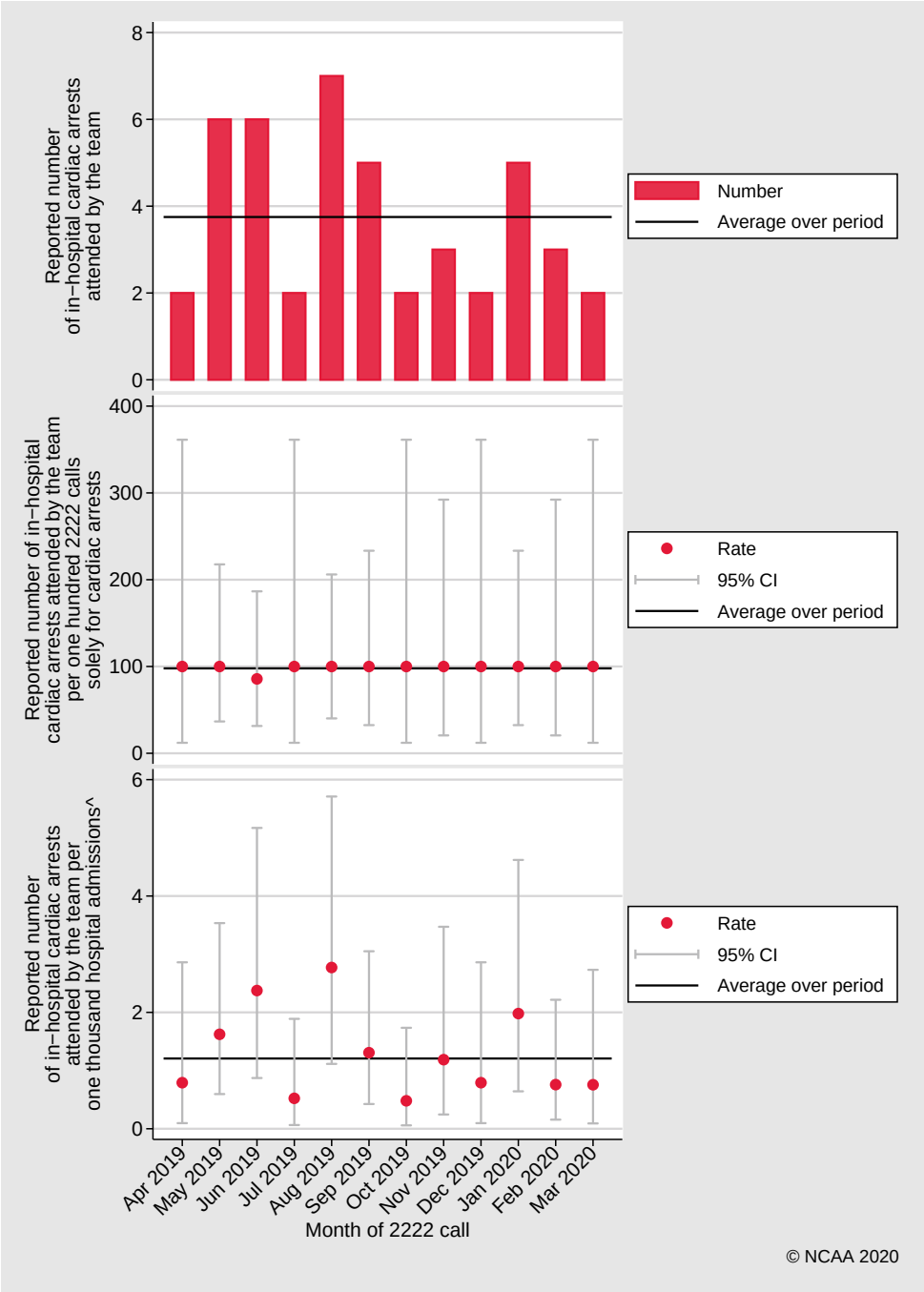
While interpreting the data in this section, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are the number and rate of cardiac arrests attended by the team as expected for your hospital?**
- **Are data being collected according to the current NCAA data collection scope (see 'Scope of Data Collection - Decision Flow' in your NCAA Data Collection Manual)?**
- **Are all cardiac arrests attended by the team being captured and entered/reported by your hospital?**
- **How might data capture or the collection of NCAA data be improved locally?**
- **How might you share tips for capturing data with other NCAA participating hospitals that may be experiencing difficulty?**

Number and rate of cardiac arrests

These graphs present the following data for your hospital (for the period that this Report covers):

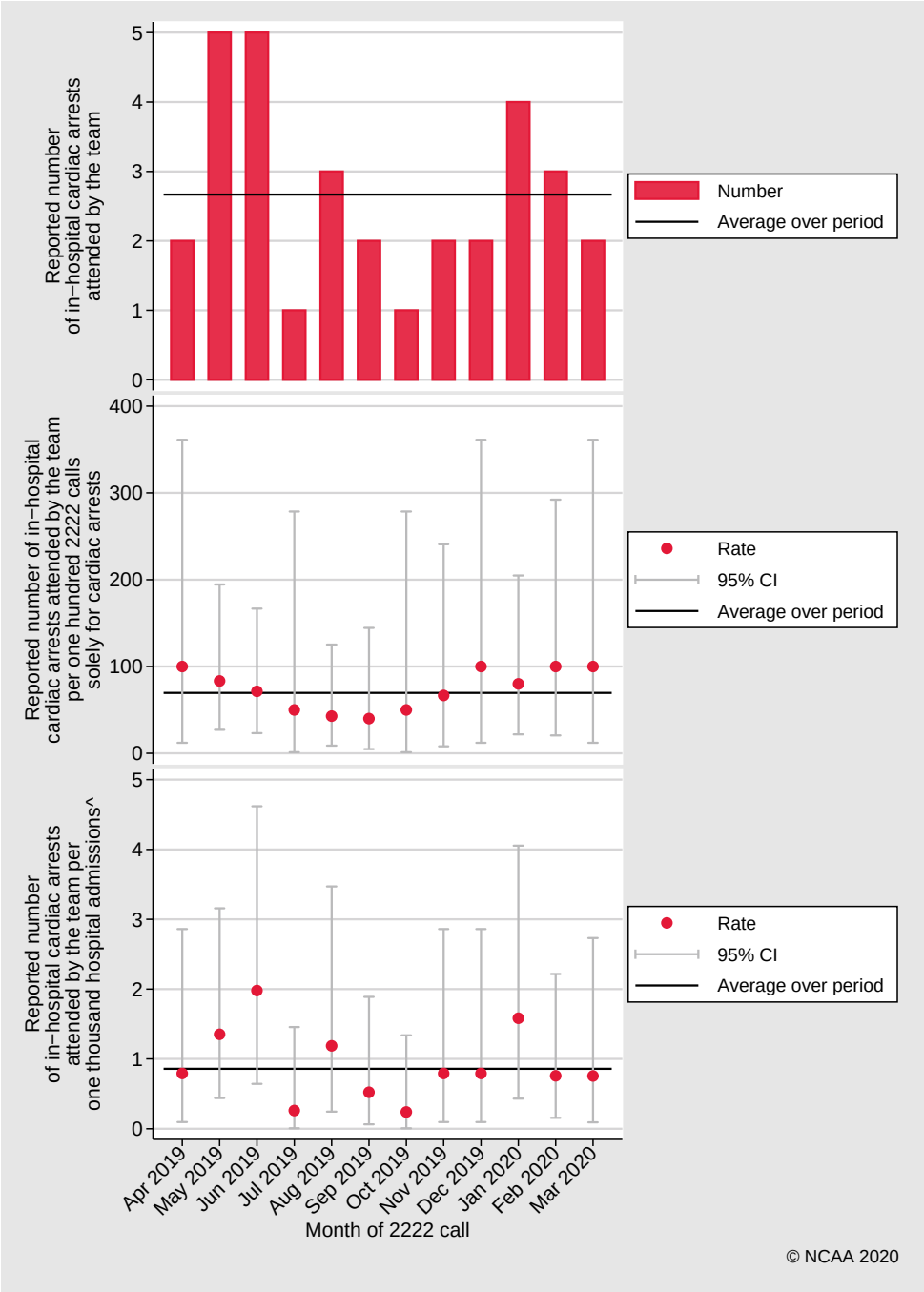
- the reported number of in-hospital cardiac arrests attended by the team;
- the rate of in-hospital cardiac arrests attended by the team against your denominator data for EITHER Total number of 2222 calls solely for cardiac arrest OR Total number of 2222 calls (depending on denominator data collected by your hospital); and
- the rate of in-hospital cardiac arrests attended by the team against your denominator data for Total number of admissions to your hospital.



Number and rate of cardiac arrests on the ward

These graphs present the following data for your hospital (for the period that this Report covers):

- the reported number of in-hospital cardiac arrests on the ward attended by the team;
- the rate of in-hospital cardiac arrests on the ward attended by the team against your denominator data for EITHER Total number of 2222 calls solely for cardiac arrest OR Total number of 2222 calls (depending on denominator data collected by your hospital); and
- the rate of in-hospital cardiac arrests on the ward attended by the team against your denominator data for Total number of admissions to your hospital.



Note:
ˆTotal includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)

Graphical presentation

In the first graph in this section, the number of in-hospital cardiac arrests attended by the team is plotted in red. The average for your hospital for the period that this Report covers is plotted by a solid black line.

In the second and third graphs above, the rate of cardiac arrests attended by the team is plotted by a red data point. The average for your hospital for the period that this Report covers is plotted by a solid black line.

95% CI (confidence interval)

- Rates plotted are displayed with a 95% confidence interval (CI) shown as the vertical grey line through each data point (see image to the left)
- Values (i.e. rates) plotted for your hospital data are estimates of the true underlying value because they are based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data (i.e. a high number of cardiac arrests attended by the team) provides a more accurate estimate of the value (rate). As the sample size increases, the precision with which a result can be calculated increases. Hence, the CI will become a narrower (shorter) vertical line.

Inversely, a small sample of data (i.e. few cardiac arrests attended by the team) provides a less accurate estimate of the value (rate). As the sample size decreases, the precision with which a result can be calculated decreases. Hence, the CI will become a wider (longer) vertical line.

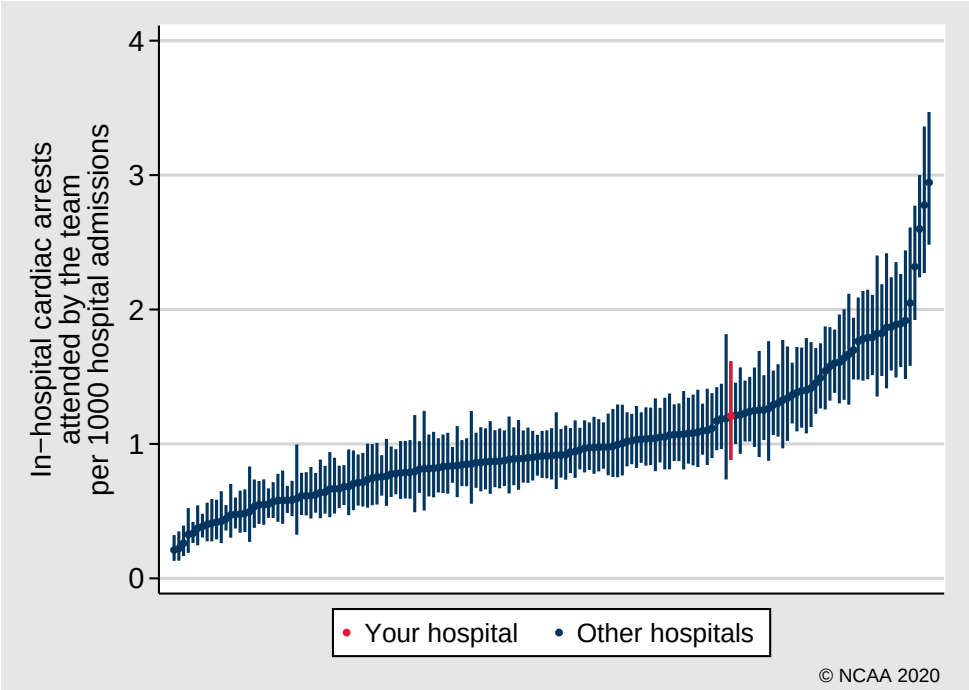
The CI, therefore, gives an indication of how accurately the value (rate) has been estimated.

A 95% CI is shown which means that 95% of the time, we would expect the true value (rate) to lie along the vertical line i.e. we are 95% confident that the true value lies within this range.

Now review suggested questions for local use at the beginning of this section!

Rate of in-hospital cardiac arrests

The following graph presents the reported number of in-hospital cardiac arrests attended by the team per 1,000 hospital admissions for adult, acute hospitals in NCAA.



Note that interpretation of these data is subject to:

- the inclusion of the most recent twelve months of validated data for all adult, acute hospitals participating in NCAA;
- the inclusion of hospitals with at least five in-hospital cardiac arrests attended by the team;
- an assumption that all hospitals are capturing the numerator and denominator data accurately; and
- variation across hospitals of types of admissions included in denominator data.

Graphical presentation

In the graph above, data for your hospital are presented in red, and data for other hospitals are presented in blue (for the period that this Report covers).

Data points plotted are displayed with a 95% confidence interval (CI) shown as the vertical line through each data point (see image to the left).

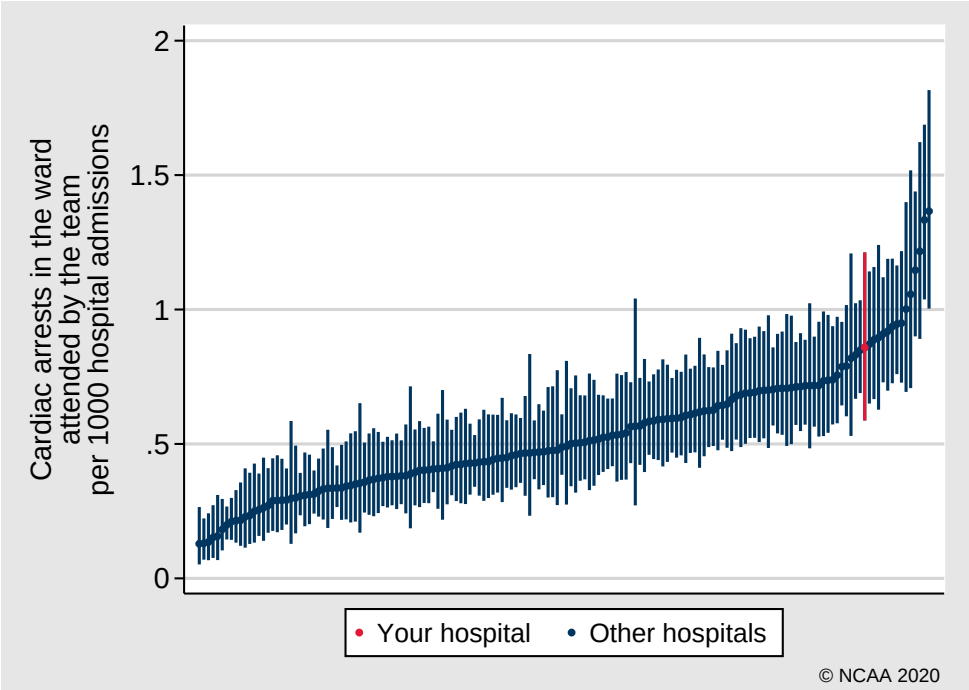
The values plotted are an estimate of the true underlying value because they are based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data provides a more accurate estimate of the value. Hence, the CI will become a narrower (shorter) vertical line. The CI, therefore, gives an indication of how accurately the value has been estimated. A 95% CI means that 95% of the time we would expect the true value to lie along the vertical line.

Note: These data are not risk adjusted

Rate of cardiac arrests - ward

The following graph presents the reported number of in-hospital cardiac arrests attended by the team where the location of arrest was ward per 1,000 hospital admissions for adult, acute hospitals in NCAA.



Note that interpretation of these data is subject to:

- the inclusion of the most recent twelve months of validated data for all adult, acute hospitals participating in NCAA;
- the inclusion of hospitals with at least five in-hospital cardiac arrests on the ward attended by the team;
- an assumption that all hospitals are capturing the numerator and denominator data accurately; and
- variation across hospitals of types of admissions included in denominator data.

Graphical presentation

In the graph above, data for your hospital are presented in red, and data for other hospitals are presented in blue (for the period that this Report covers).

Data points plotted are displayed with a 95% confidence interval (CI) shown as the vertical line through each data point (see image to the left).

The values plotted are an estimate of the true underlying value because they are based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data provides a more accurate estimate of the value. Hence, the CI will become a narrower (shorter) vertical line. The CI, therefore, gives an indication of how accurately the value has been estimated. A 95% CI means that 95% of the time we would expect the true value to lie along the vertical line.

Note: These data are not risk adjusted

4. Data completeness

This section provides you with an overview of the completeness of all your NCAA data for all reported in-hospital cardiac arrests attended by the team. The following graph illustrates how complete data are for each field in the NCAA dataset.

These are displayed in the following groupings:

- patient characteristics and hospital admission;
- 2222 call and team visit/arrest; and
- post-arrest location and outcome.

On the graph, a red bar indicates where data are incomplete (less than 100%) for a given field and a blue bar indicates where data are complete (100%).

On the beginning of each bar, the number of complete team visit records (i.e. cardiac arrests attended by the team), relative to the number required to be complete, is presented. For example, 10/13 means 10 out of 13 team visit records had complete data for this dataset field.

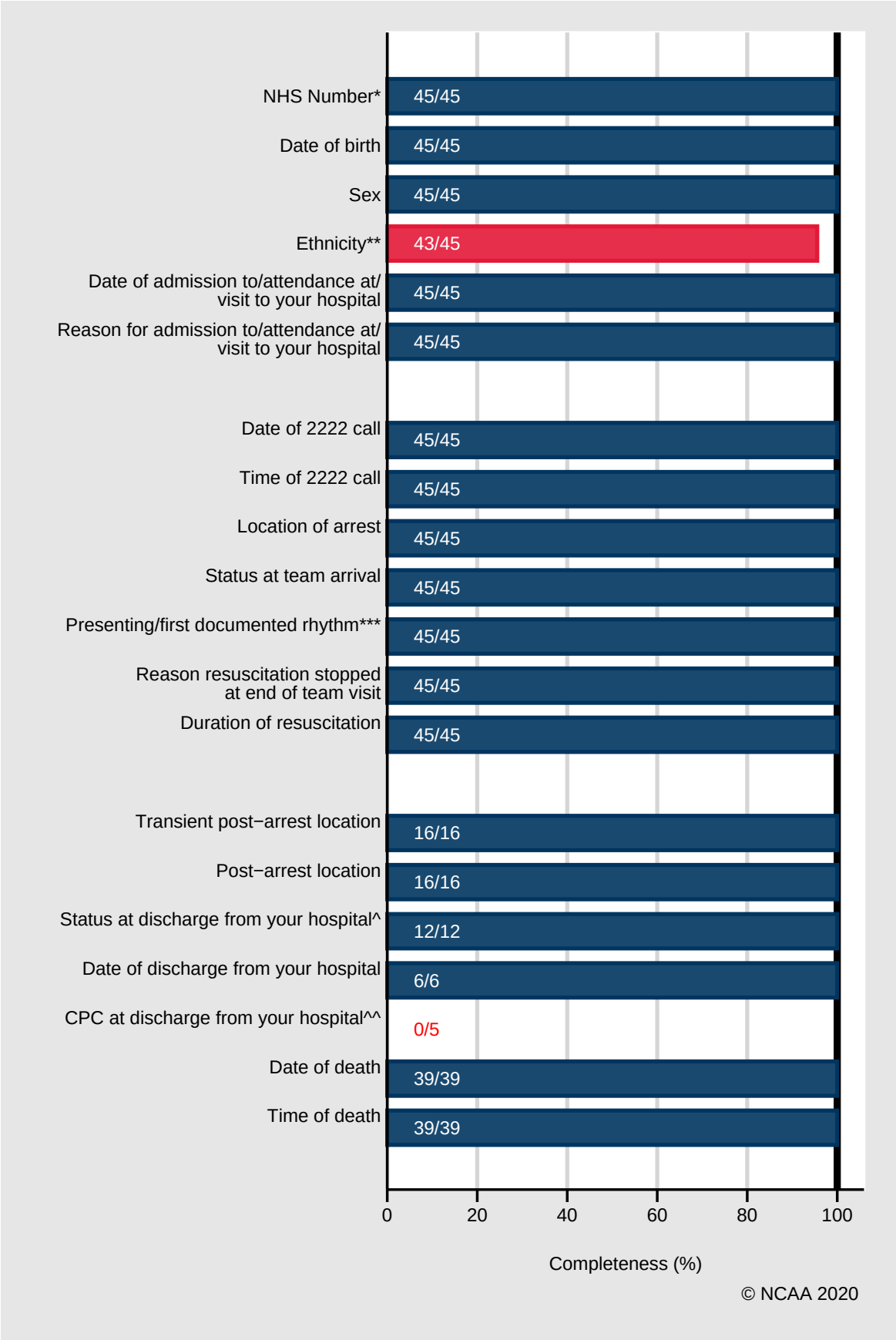
For definitions of the dataset fields in this section, refer to the current NCAA Data Collection Manual.

Suggested questions for local use

While interpreting these data on data completeness, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Is your hospital fully collecting every field in the NCAA dataset?**
- **How could your hospital:**
  - **improve the quality of data collection?**
  - **increase the speed of data collection/entry?**
  - **reduce the number of validation queries?**
  - **increase the speed of processing validation queries?**

Data completeness



Footnotes relating to the completeness graph on previous page:

* n = 0 team visit records where individual was recorded as a "Non-UK patient" (these are considered as complete data)

** n = 2 team visit records where individual had ethnicity recorded as "Not stated" (these are considered as incomplete data)

*** n = 0 team visit records where individual had presenting/first documented rhythm recorded as "Unknown" (these are considered as incomplete data)

n = 5 team visit records where individual had presenting/first documented rhythm recorded as "Never determined" (these are considered as complete data)

ˆ n = 0 team visit records where individual is recorded as "patient still in your hospital" (excluded from the denominator)

ˆˆ n = 1 team visit records where individual is recorded as sedated (excluded from the denominator)

Now review suggested questions for local use at the beginning of this section!

5. Activity

Activity analyses for in-hospital cardiac arrests attended by the team are presented for your hospital and are compared against NCAA for adult, acute hospitals, for the period that this Report covers.

Trended analyses on activity for your hospital are presented against NCAA data for adult, acute hospitals by quarter/six month periods/year (dependent on the sample size of data for your hospital).

Graphs are presented under the following headings:

- patient characteristics;
- cardiac arrests attended by the team;
- location of arrest;
- status at team arrival; and
- presenting/first documented rhythm.

Graphical presentation

Data for your hospital are plotted on each graph in red, and NCAA plotted in blue.

On each bar graph, cardiac arrests attended by the team for each category are presented as a percentage on the y axis (vertical) and as the number on the top of each bar.

On each trended graph, the y axis (vertical) presents one of the following:

- percentage of cardiac arrests attended by the team;
- mean values;
- number of cardiac arrests attended by the team; or
- rate.

For trended graphs, the sample size for each period (i.e. quarter/six month/year) for your hospital is presented just above the x axis (horizontal). This can provide an indication of the accuracy of the data plotted (i.e. a larger sample size can mean a more accurate data point).

Note: Trended graphs will be missing data points if a quarter/six month period/year is incomplete, either because that period contains unvalidated data or data was not submitted during that period.

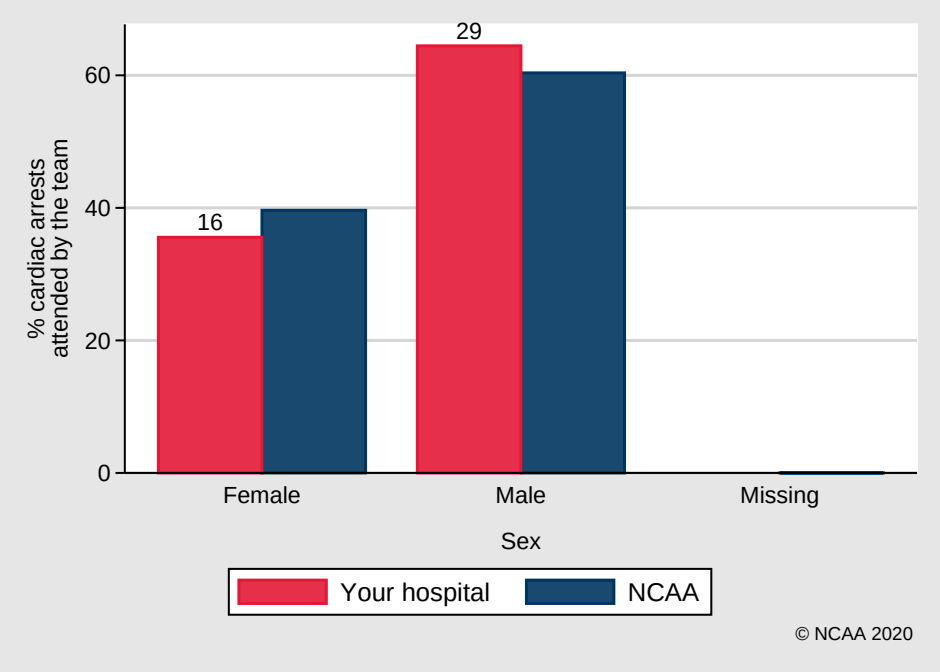
Patient characteristics

Suggested questions for local use

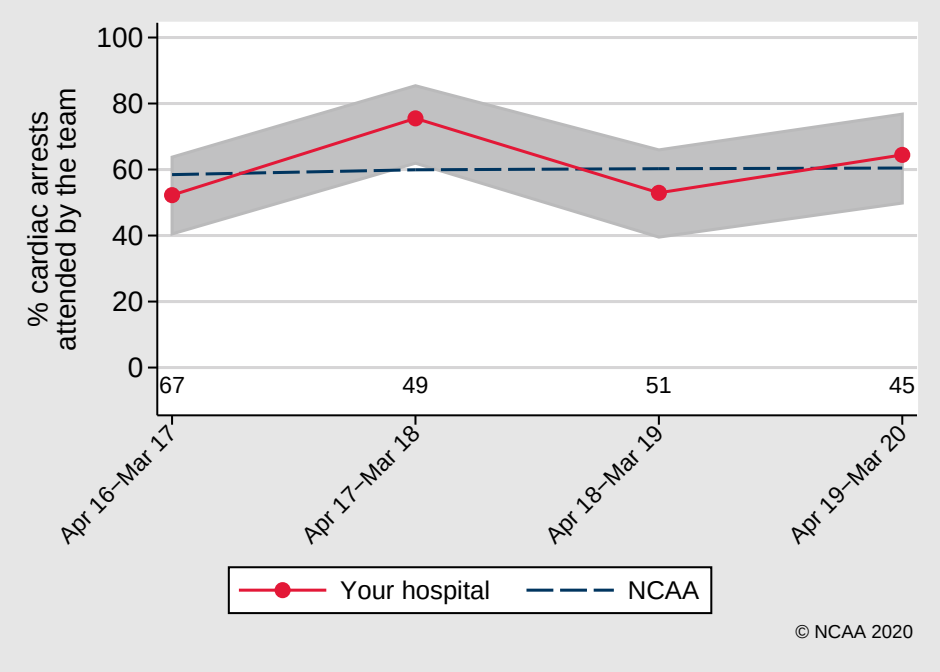
While interpreting these data on patient characteristics, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there any trends in patient characteristics for your hospital?**
- **How might patient characteristics be affecting the care you deliver?**
- **How does seasonal variation affect patient characteristics?**
- **How could these data on patient characteristics be used for planning Resuscitation Team responses and wider service planning at your hospital?**

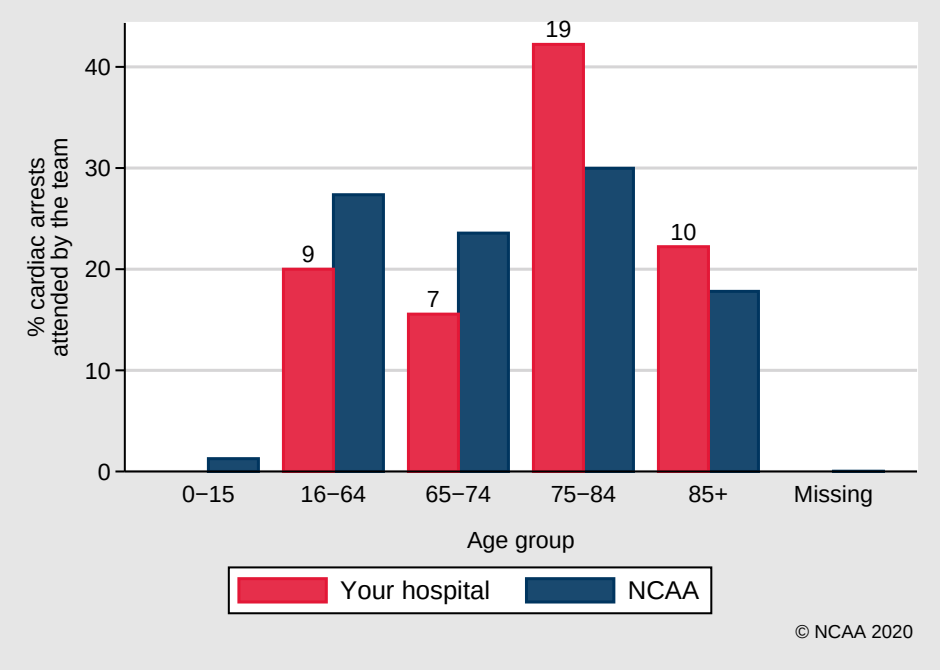
Sex



Sex (males) - trended

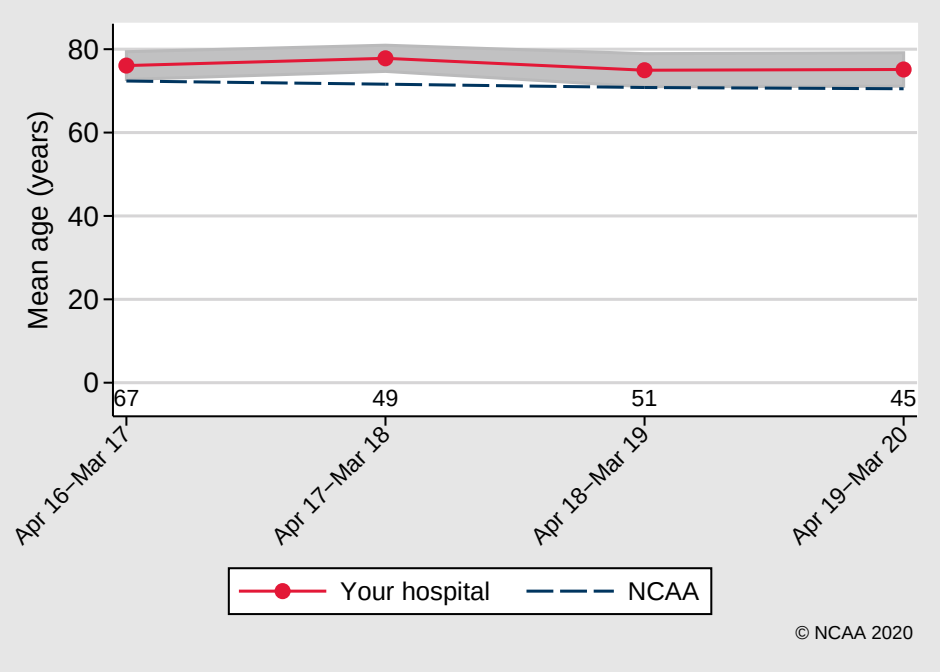


Age



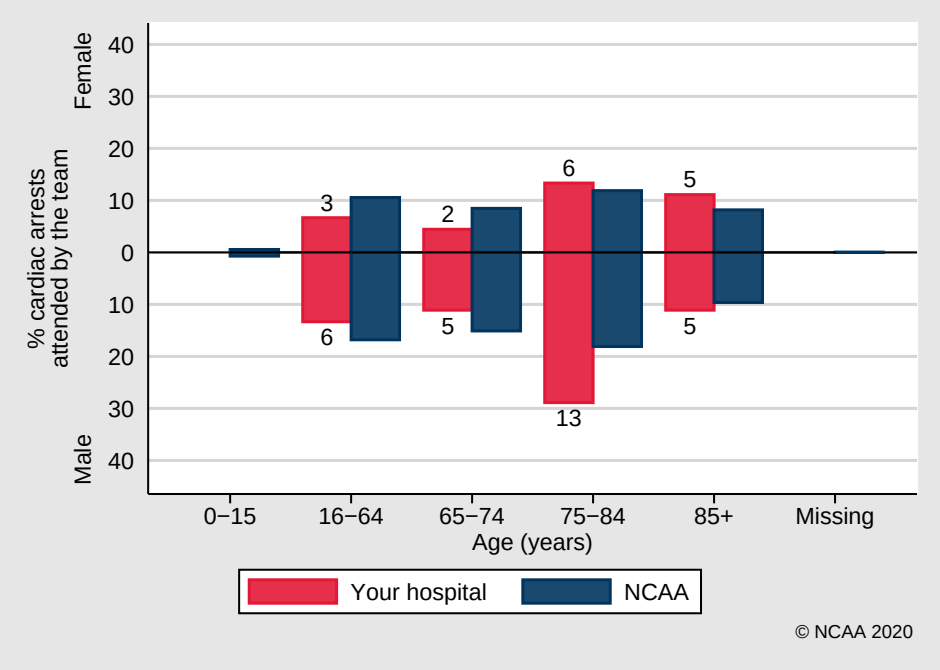
Note: n = 0 estimated age (included)

Mean age - trended



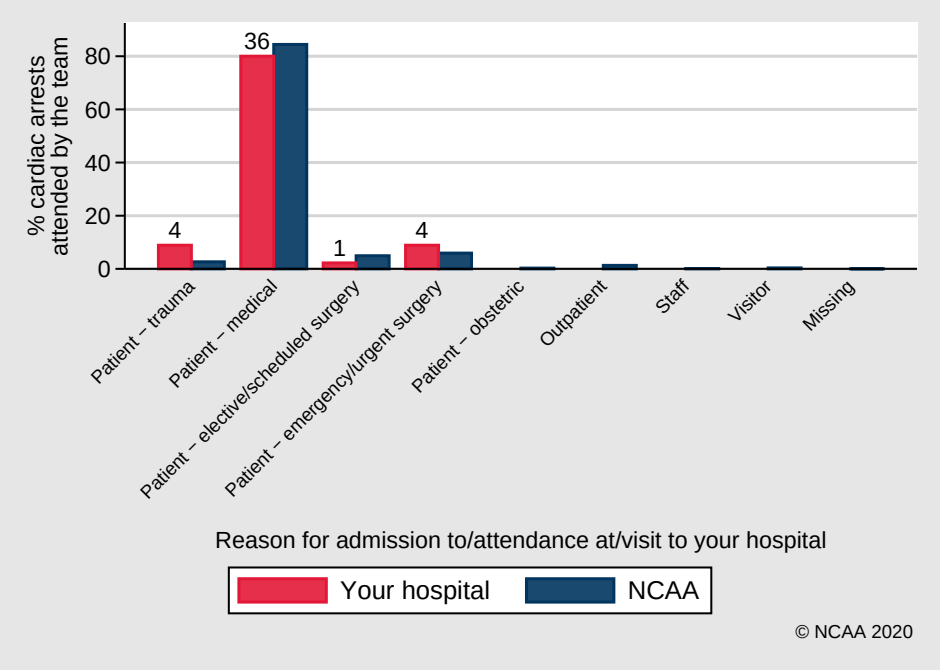
Mean age is calculated by summing the ages of the individuals for each cardiac arrest attended by the team and dividing by the number of cardiac arrests attended by the team

Age by sex



Note: n = 0 estimated age (included)

Reason for admission to/attendance at/visit to your hospital



Now review suggested questions for local use at the beginning of this section!

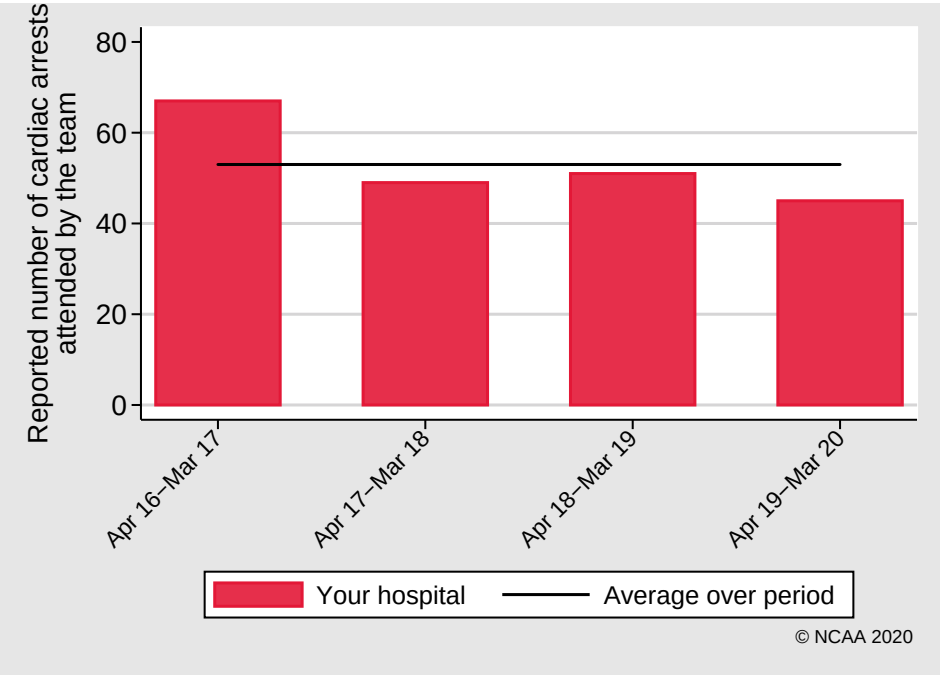
Cardiac arrests attended by the team

Suggested questions for local use

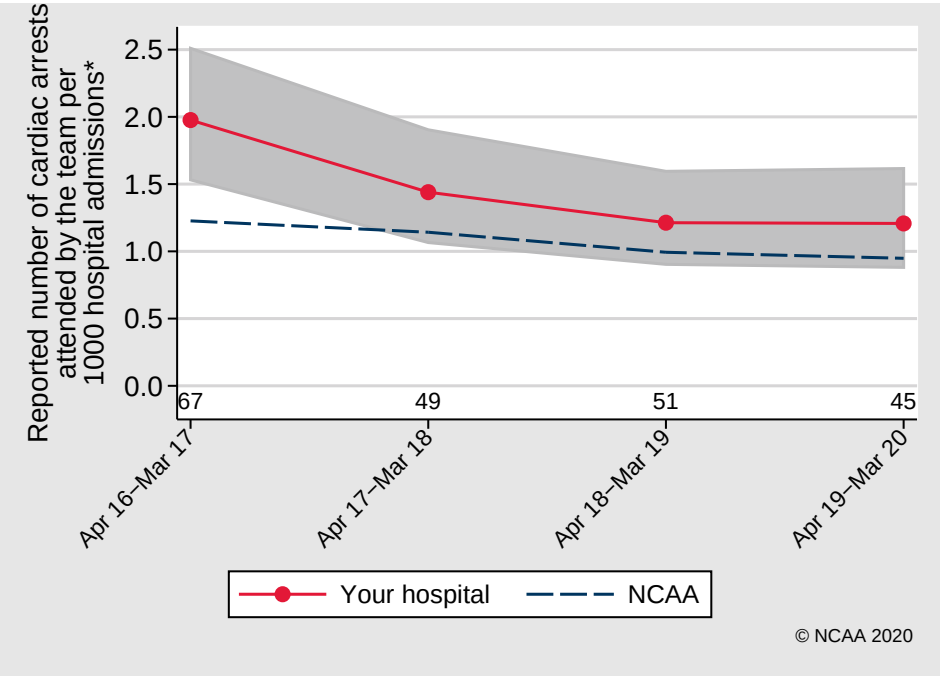
While interpreting these data on cardiac arrests attended by the team, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there any trends in the number/rate/incidence of cardiac arrests attended by the team?**
- **How does seasonal variation affect cardiac arrests attended by the team?**
- **How could these data on cardiac arrests attended by the team be used for planning Resuscitation Team responses and wider service planning at your hospital?**

Number of cardiac arrests attended by the team - trended

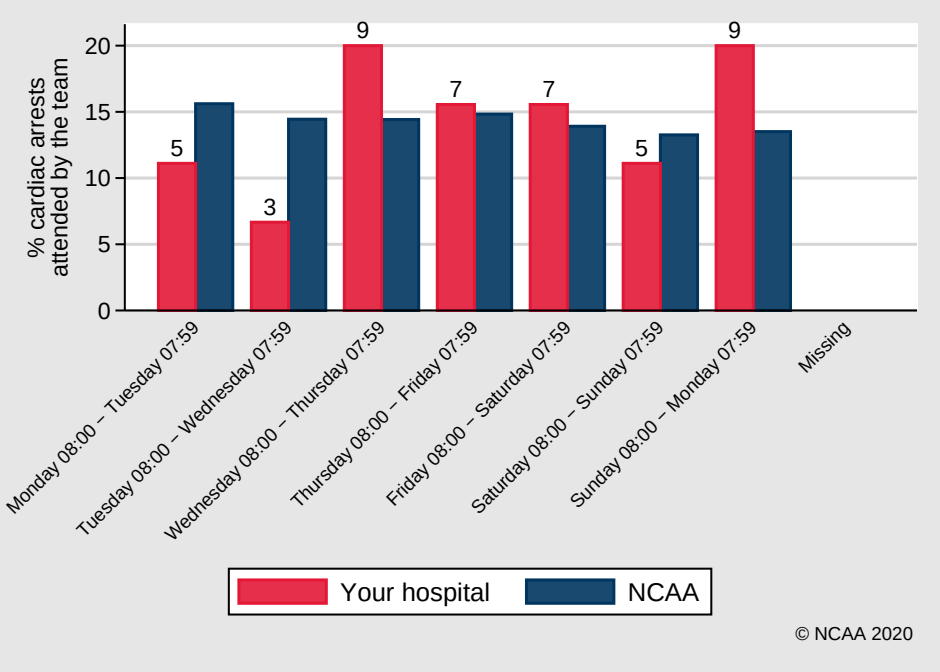


Rate of cardiac arrests attended by the team per 1000 hospital admissions - trended

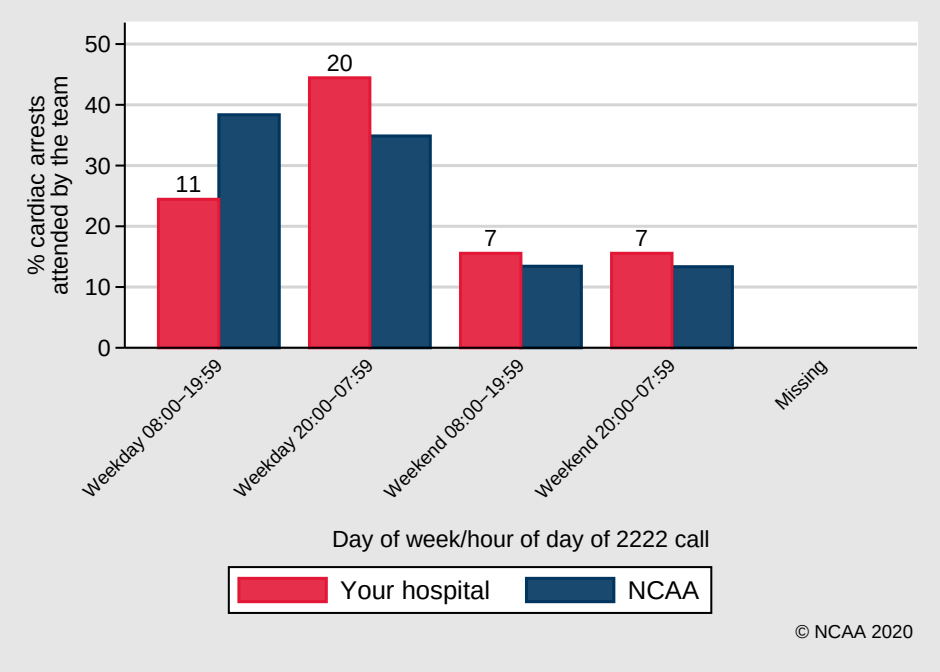


*Total includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)

Day of week of cardiac arrests attended by the team

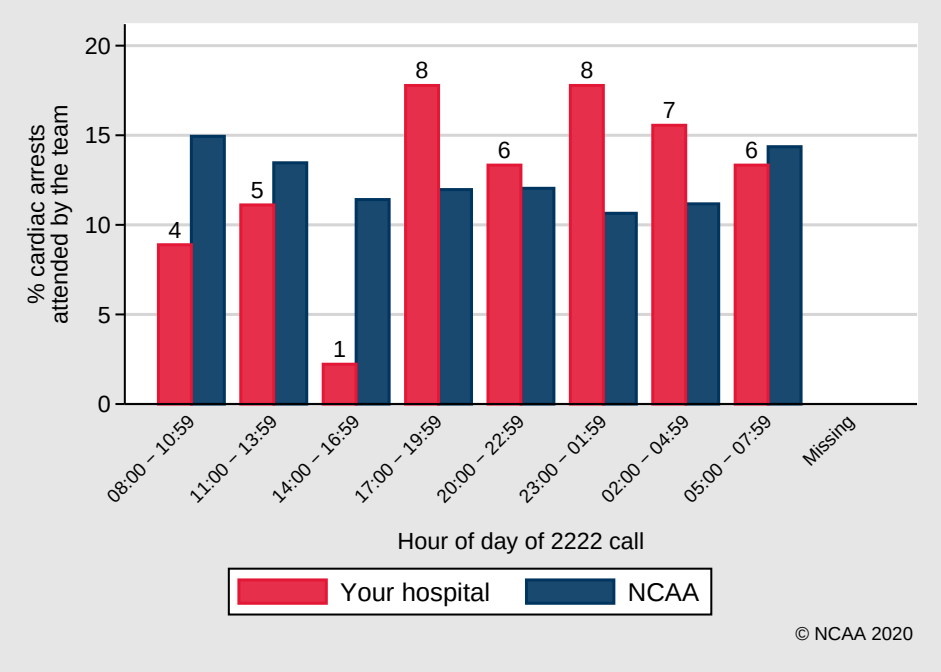


Day of week/hour of day of cardiac arrests attended by the team

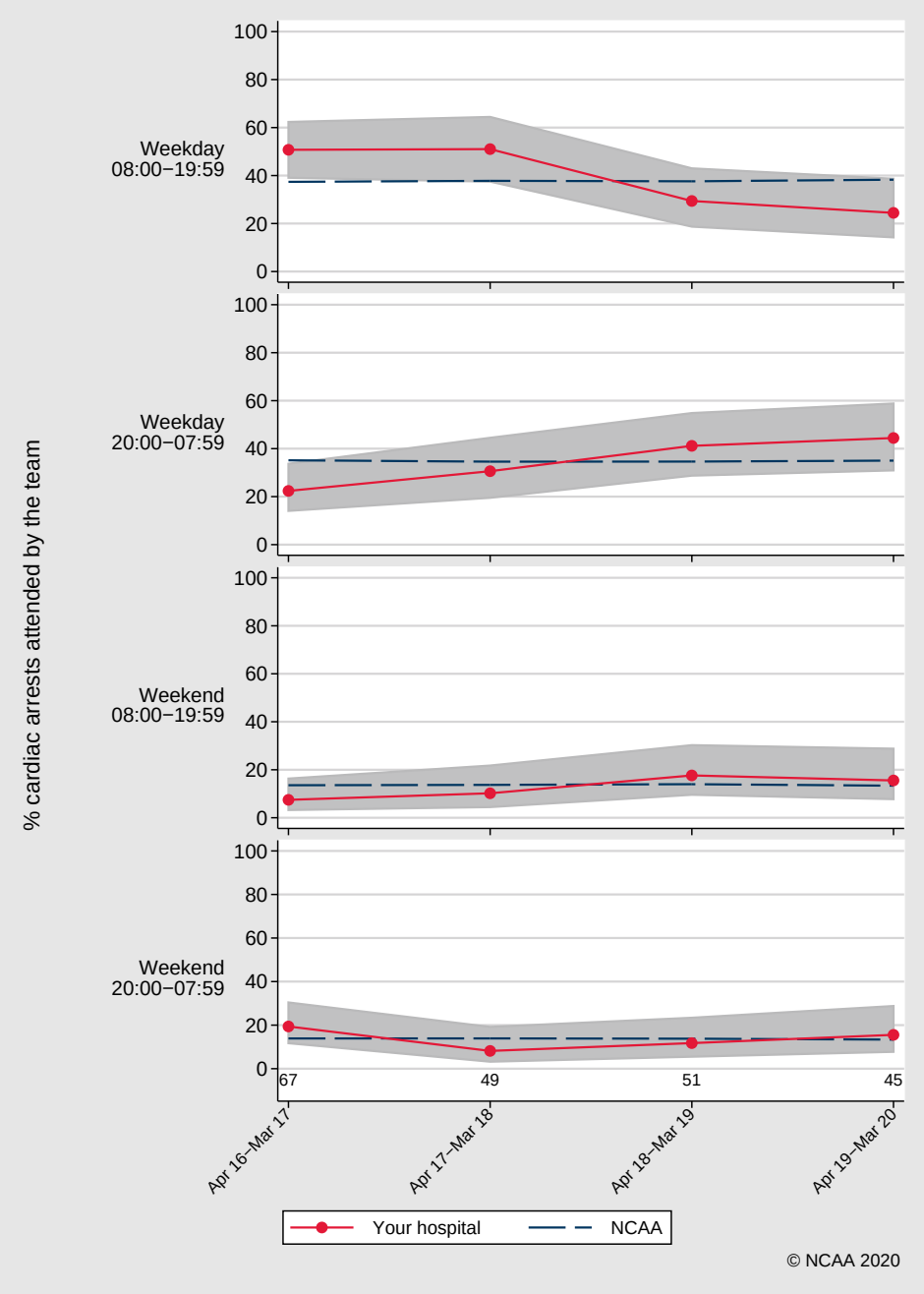


Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

Hour of day of cardiac arrests attended by the team

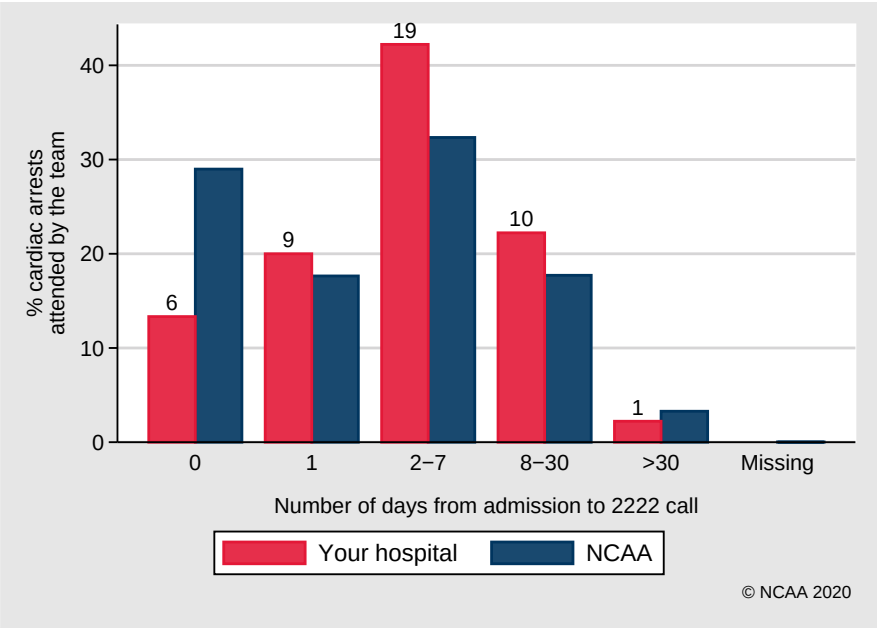


Day of week/hour of day of cardiac arrests attended by the team - trended

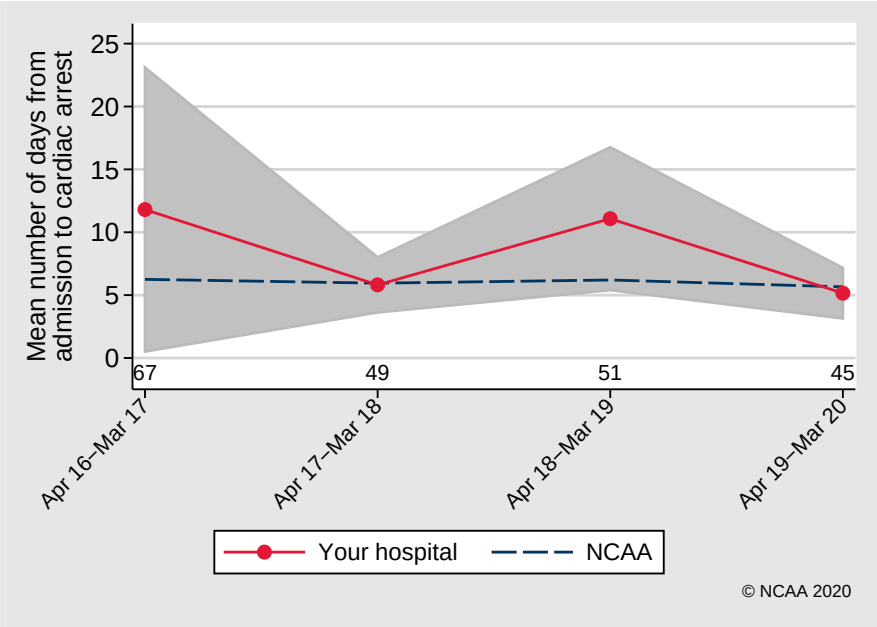


Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

Number of days from admission to cardiac arrests attended by the team



Mean number of days from admission to cardiac arrests attended by the team - trended



Mean number of days is calculated by summing the number of days for each cardiac arrest attended by the team and dividing by the number of cardiac arrests attended by the team

Now review suggested questions for local use at the beginning of this section!

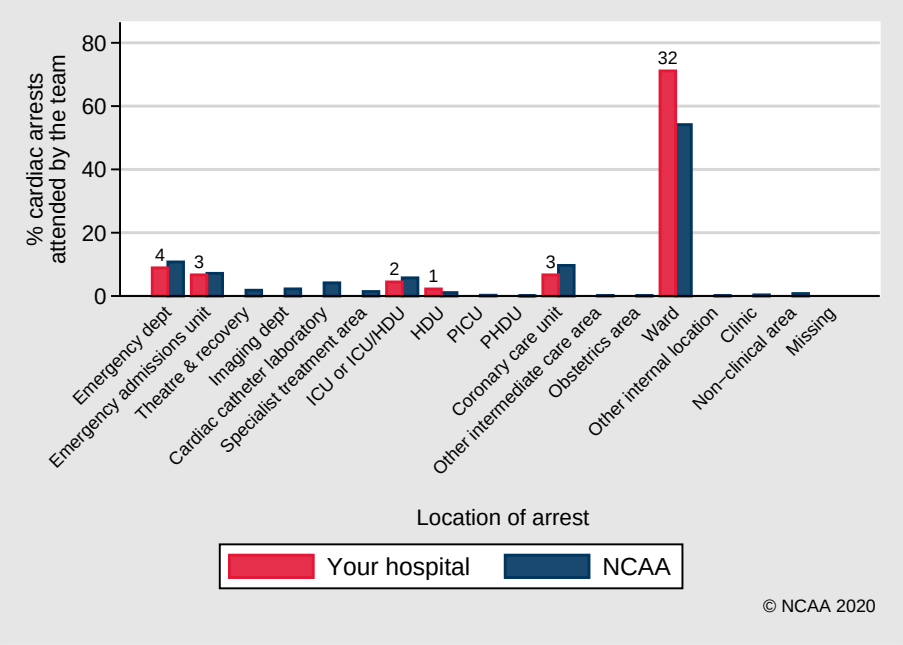
Location of arrest

Suggested questions for local use

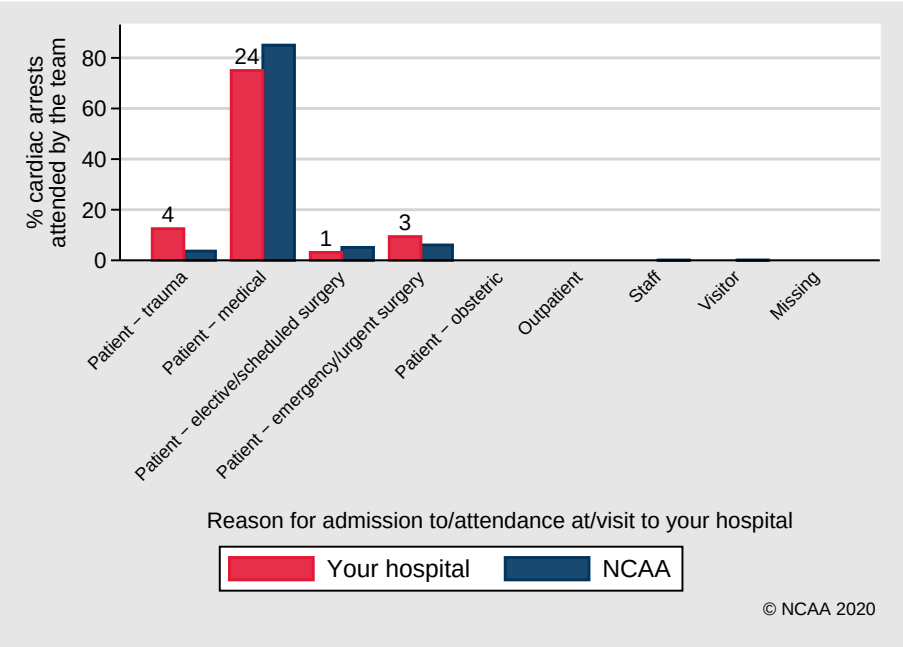
While interpreting these data on location of arrest, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there any trends in the location of cardiac arrests attended by the team and reason for admission to your hospital?**
- **How could these data on location of cardiac arrests attended by the team be used for planning Resuscitation Team responses and wider service planning at your hospital?**

Location of arrest



Ward arrests by reason for admission to/attendance at/ visit to your hospital



Note: The above graph only includes reported cardiac arrests attended by the team where location of arrest is ward

Now review suggested questions for local use at the beginning of this section!

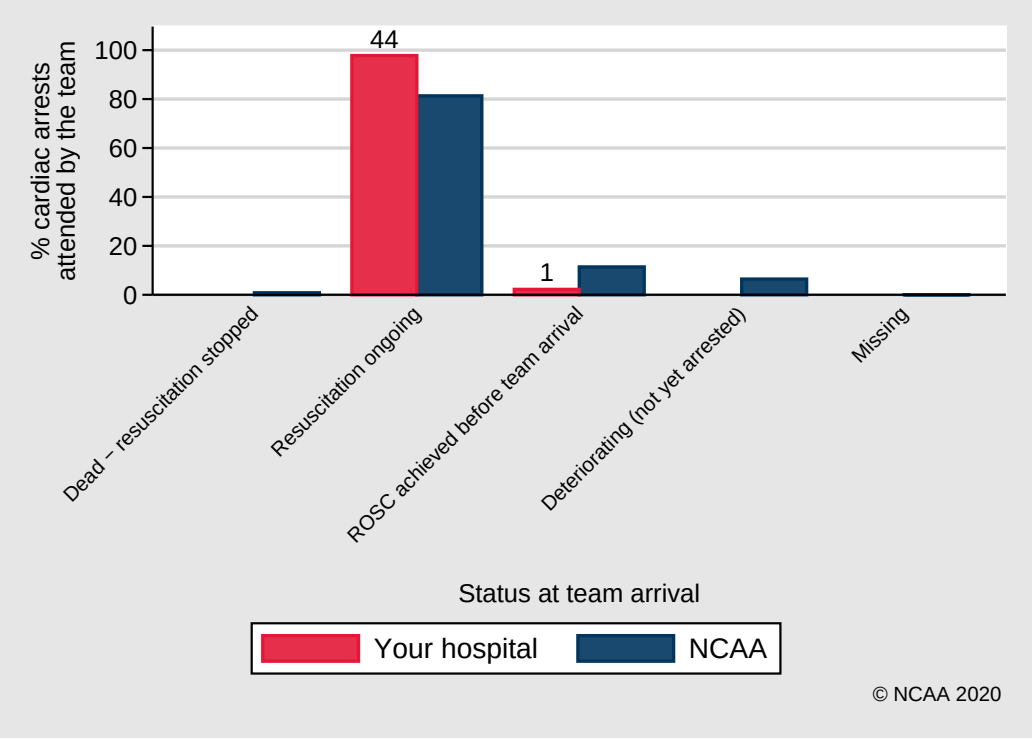
Status at team arrival

Suggested questions for local use

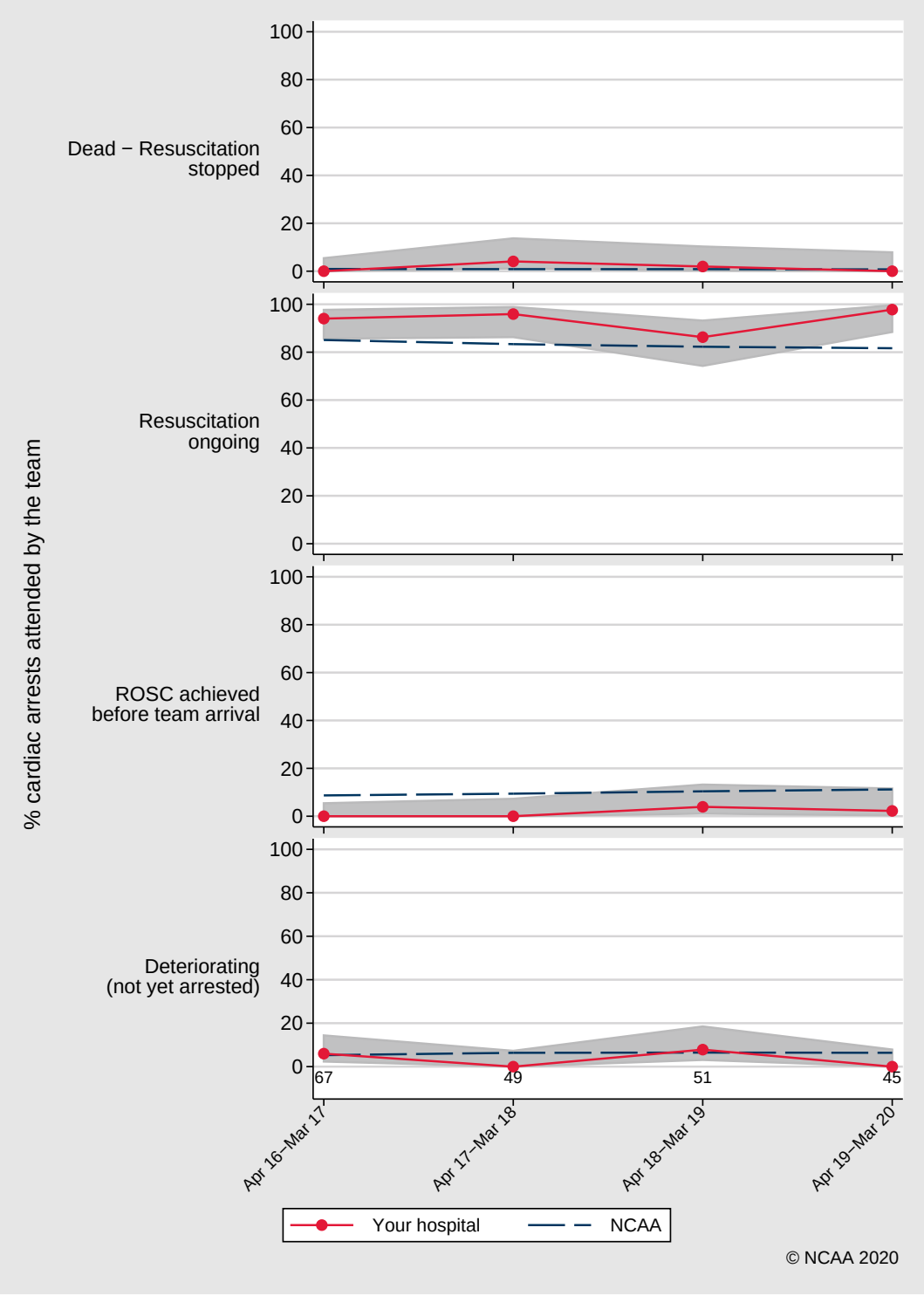
While interpreting these data on status at team arrival, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there trends in status at team arrival for cardiac arrests attended by the team?**
- **How could these data on status at team arrival be used for planning Resuscitation Team responses?**
- **How could these data on status at team arrival be used for wider service planning at your hospital?**

Status at team arrival



Status at team arrival - trended



Now review suggested questions for local use at the beginning of this section!

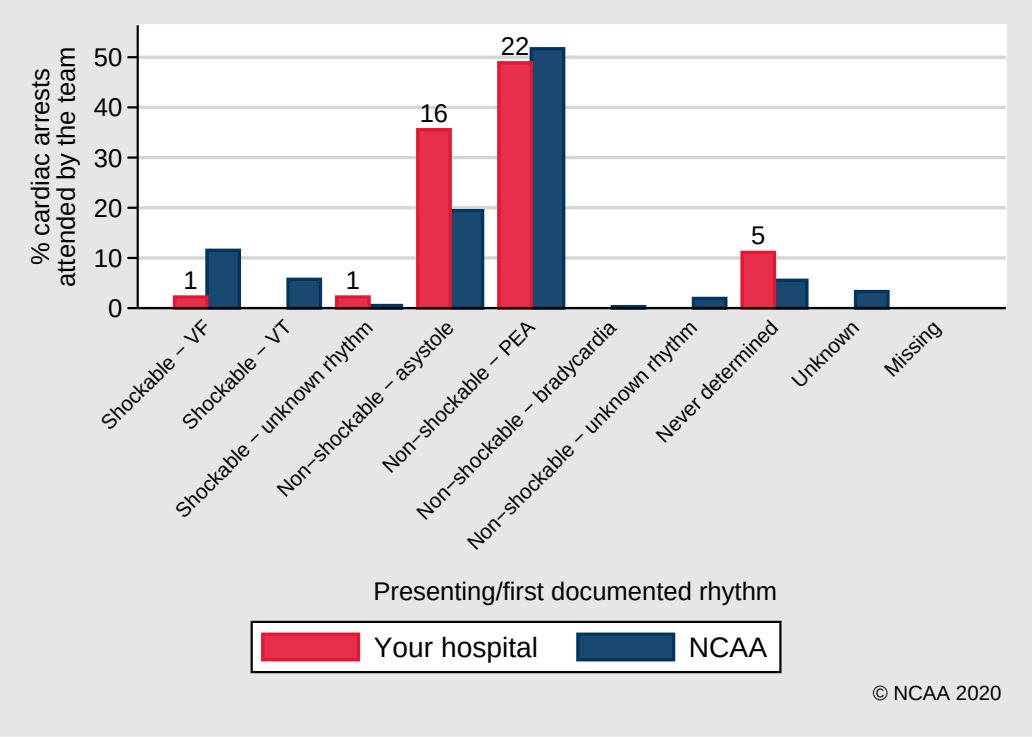
Presenting/first documented rhythm

Suggested questions for local use

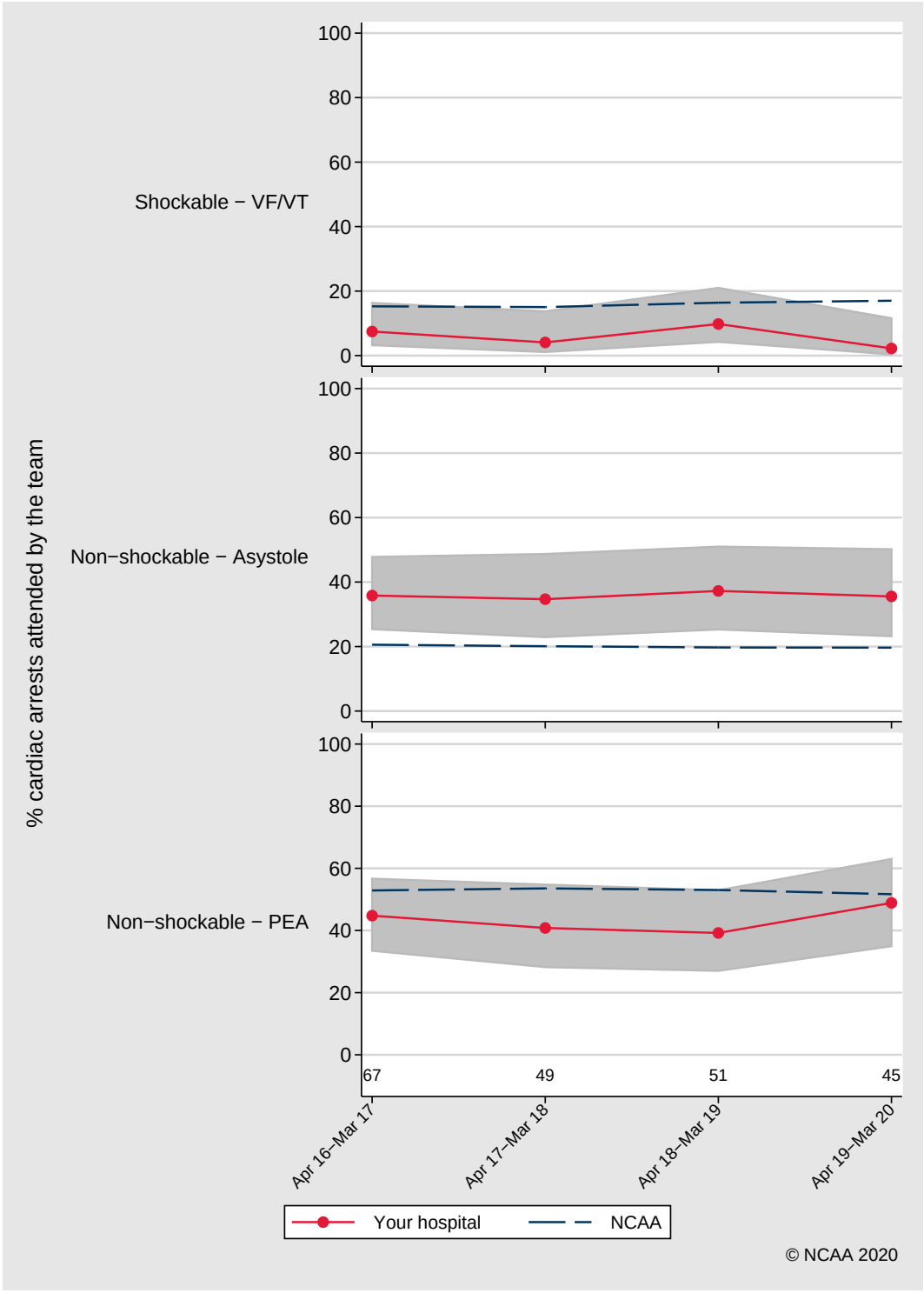
While interpreting these data on presenting/first documented rhythm, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there any trends in the presenting/first documented rhythm for cardiac arrests attended by the team?**
- **How could these data on presenting/first documented rhythm be used for planning Resuscitation Team responses and wider service planning at your hospital?**
- **What patterns are present in your activity data?**

Presenting/first documented rhythm



Presenting/first documented rhythm - trended



Now review suggested questions for local use at the beginning of this section!

6. Outcome

Analyses on outcome for in-hospital cardiac arrests attended by the team are presented for your hospital and are compared against NCAA data for adult, acute hospitals, for the period that this Report covers.

Trended analyses on activity for your hospital are presented against NCAA data for adult, acute hospitals by quarter/six month periods/year (dependent on the sample size of data for your hospital).

Graphs are grouped and presented under the following headings:

- reason resuscitation stopped;
- post-arrest location;
- status at hospital discharge (from your hospital); and
- CPC at discharge (from your hospital).

Graphical presentation

Data for your hospital are plotted on each graph in red, and NCAA plotted in blue.

On each bar graph, cardiac arrests attended by the team/number of individuals for each category are presented as a percentage on the y axis (vertical) and as a number on the top of each bar.

On each trended graph, the y axis (vertical) presents one of the following:

- percentage of cardiac arrests attended by the team; or
- percentage of individuals.

For trended graphs, the sample size for each period (i.e. quarter/six month/year) for your hospital is presented just above the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point).

Note: Trended graphs will be missing data points if a quarter/six month period/year is incomplete, either because that period contains unvalidated data or data was not submitted during that period.

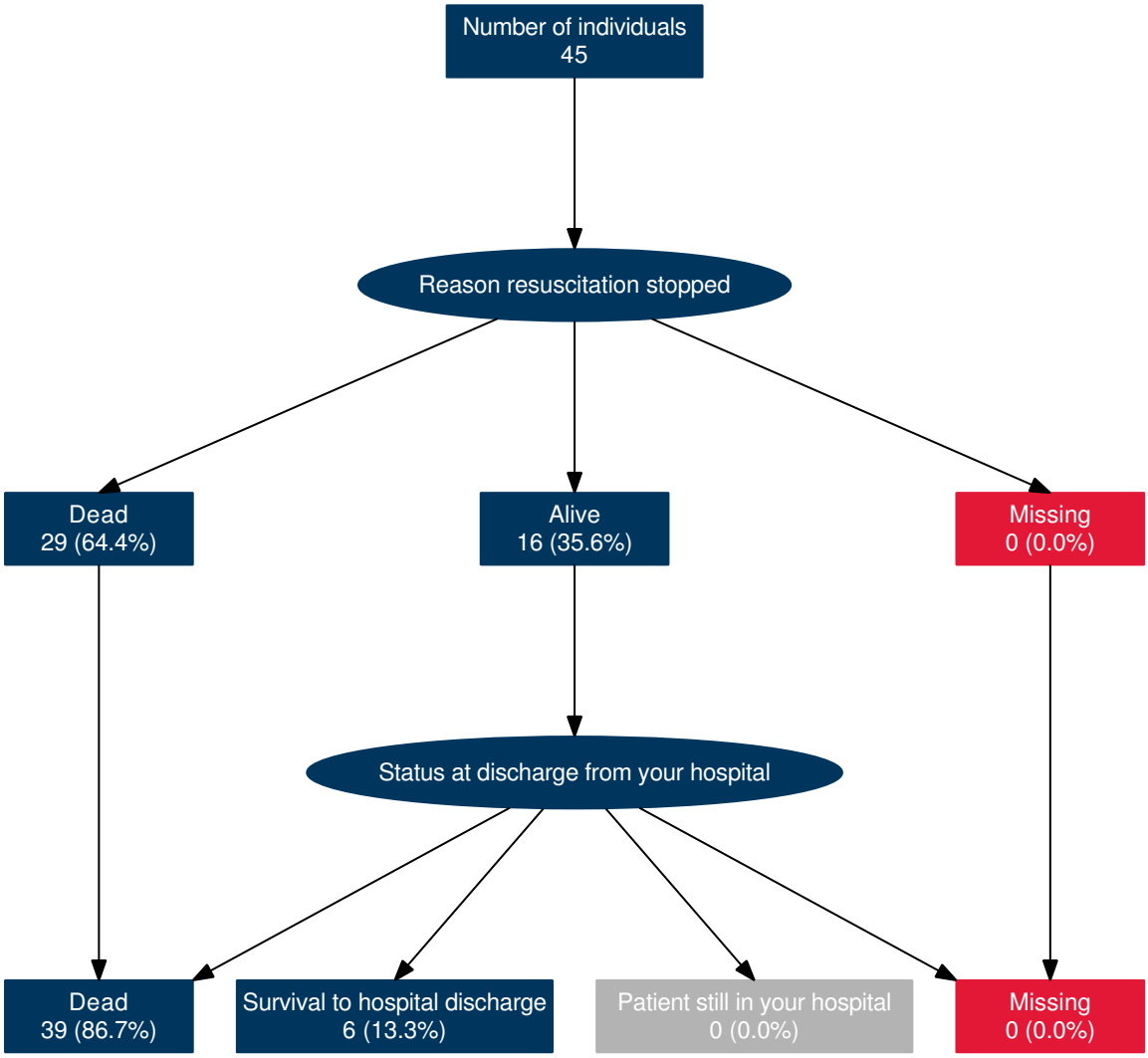
Suggested questions for local use

While interpreting these data on outcome, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **Are there any unexpected mortalities or unexpected survivors?**
- **Is there a need to identify and review any specific cardiac arrests attended by the team?**
- **How could these data be used for planning Resuscitation Team responses?**

Outcome flow

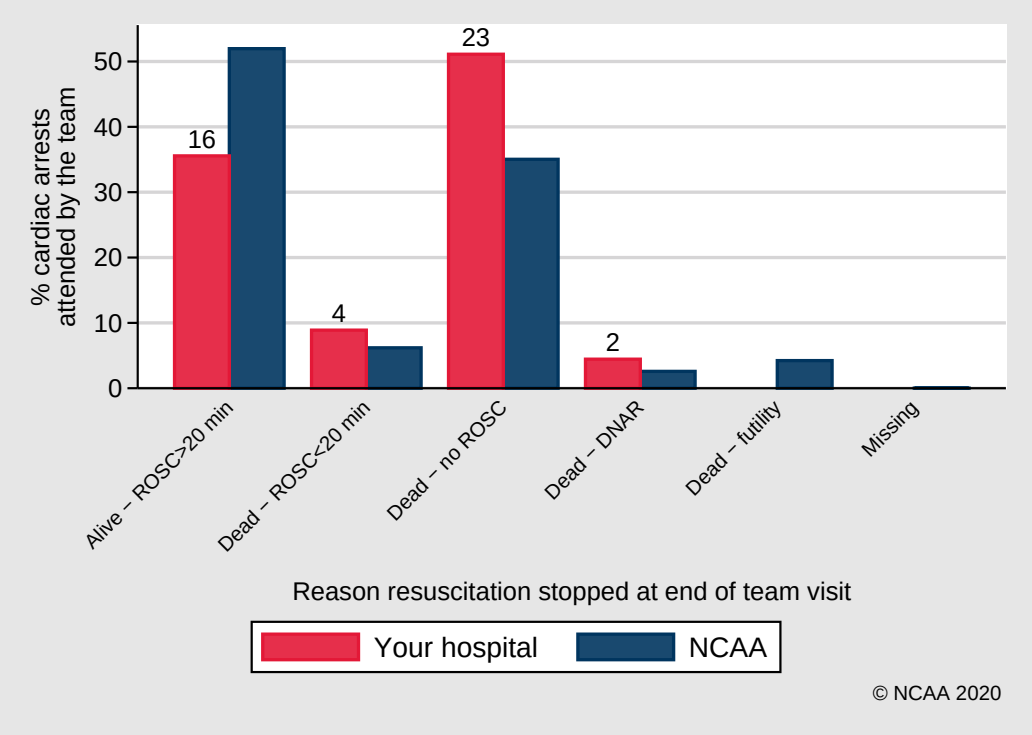
Outcome flow



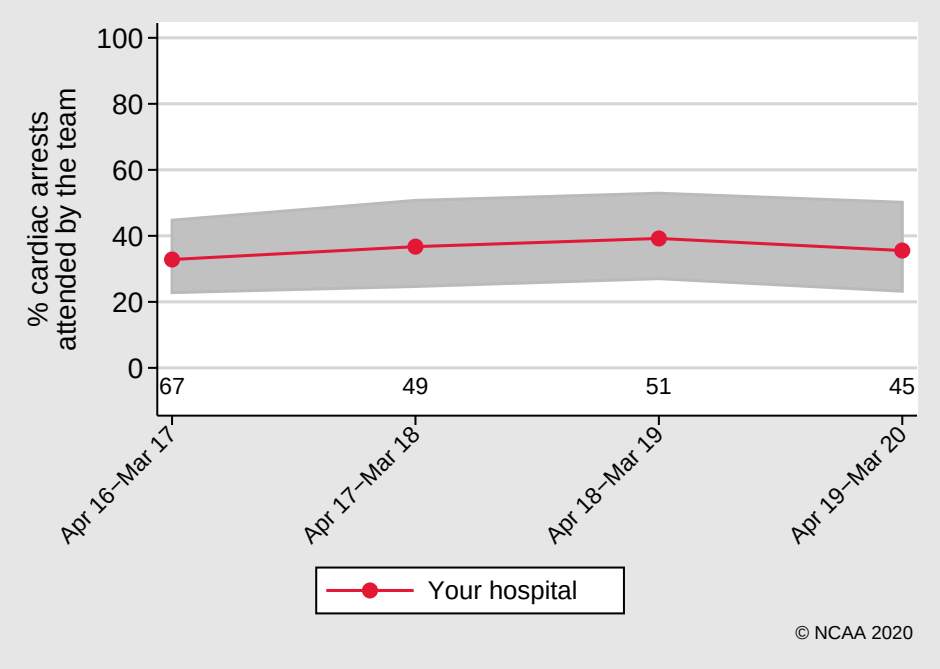
Note: All percentages shown in this flow are calculated from the overall number of individuals

Reason resuscitation stopped

Reason resuscitation stopped at end of team visit

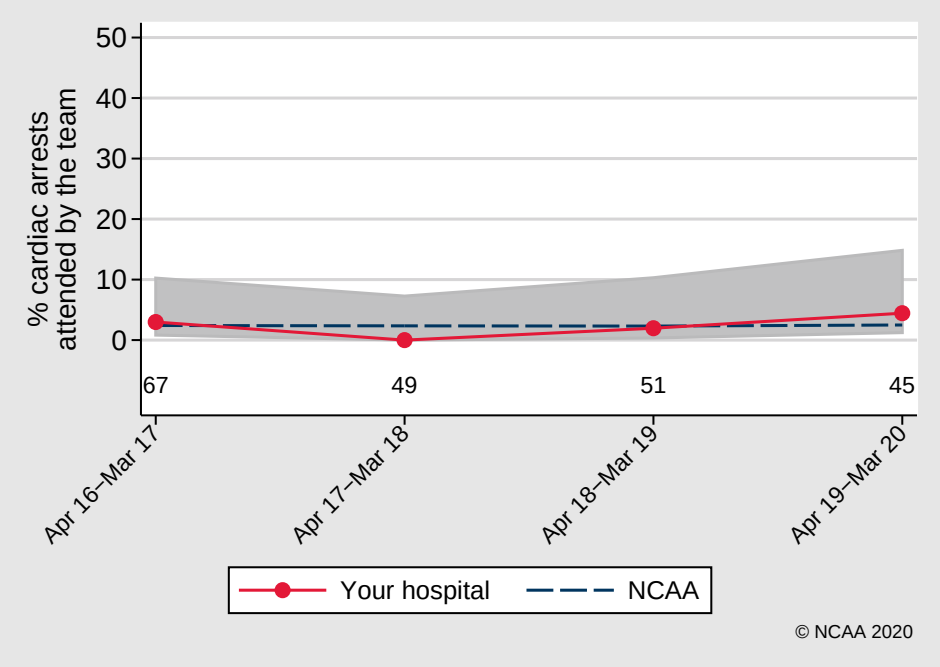


Reason resuscitation stopped at end of team visit (Alive - ROSC>20mins) - trended

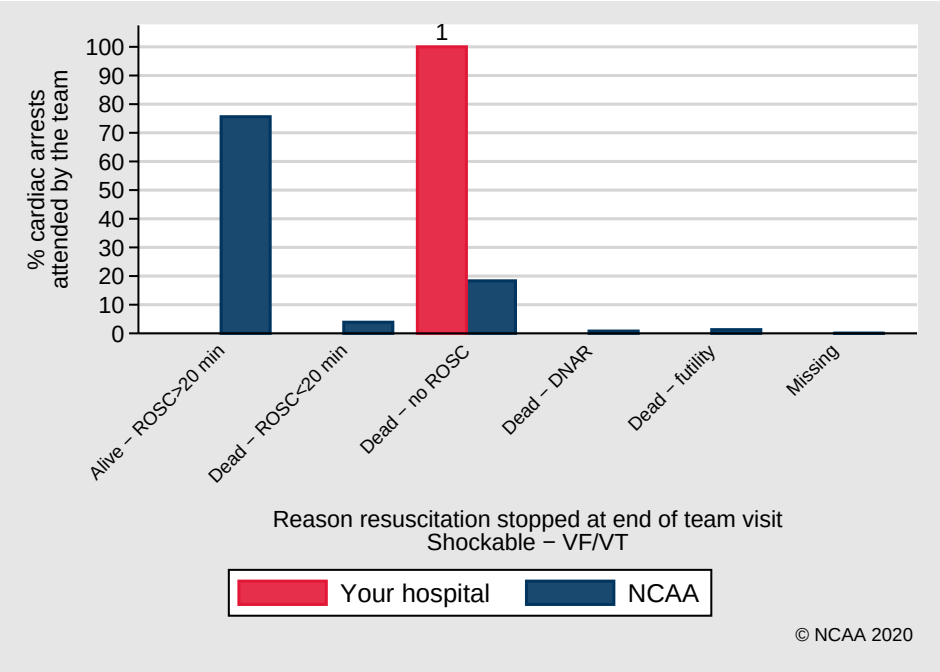


Note: NCAA comparator data are not plotted as these data are not risk adjusted

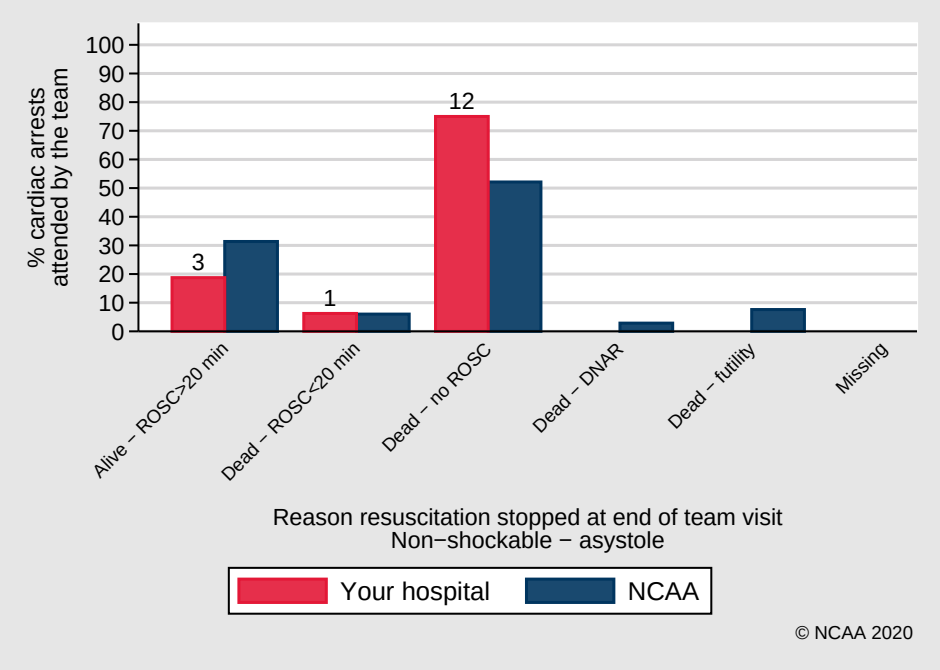
Reason resuscitation stopped at end of team visit (Dead - DNAR) - trended



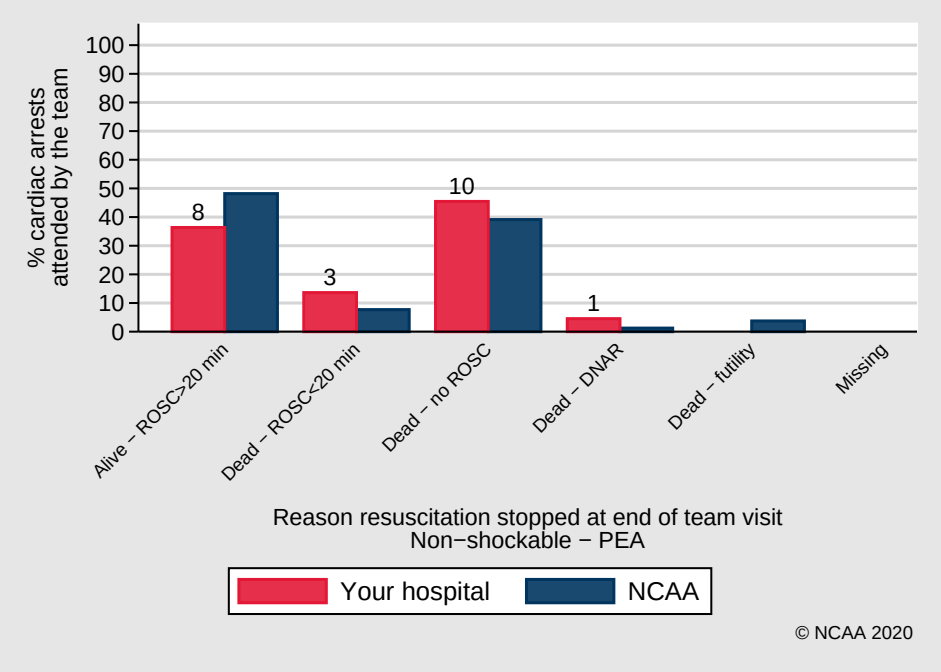
Reason resuscitation stopped at end of team visit for shockable - VF/VT



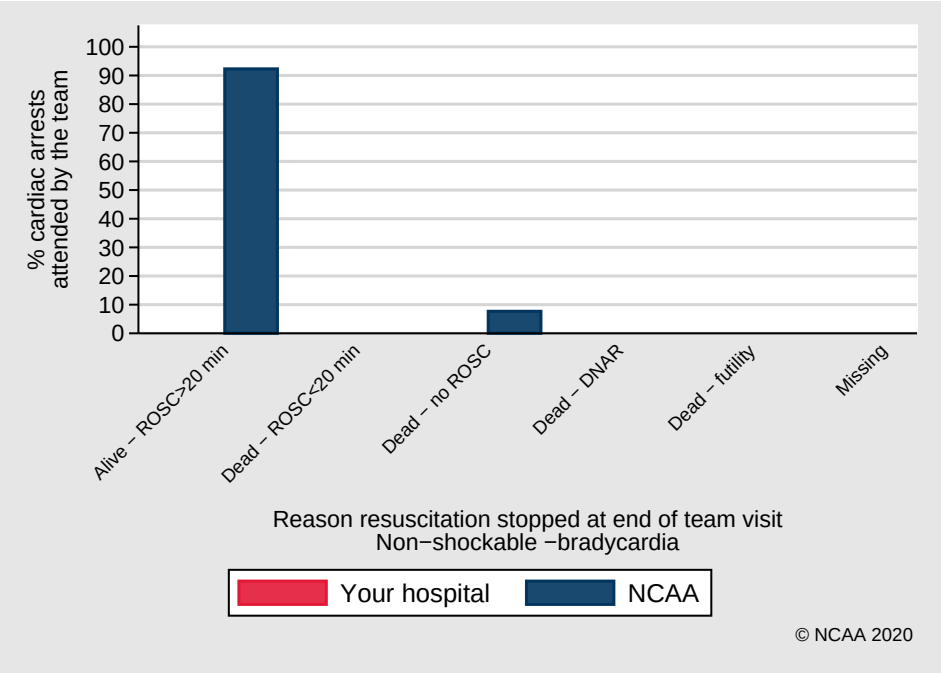
Reason resuscitation stopped at end of team visit for non-shockable - asystole



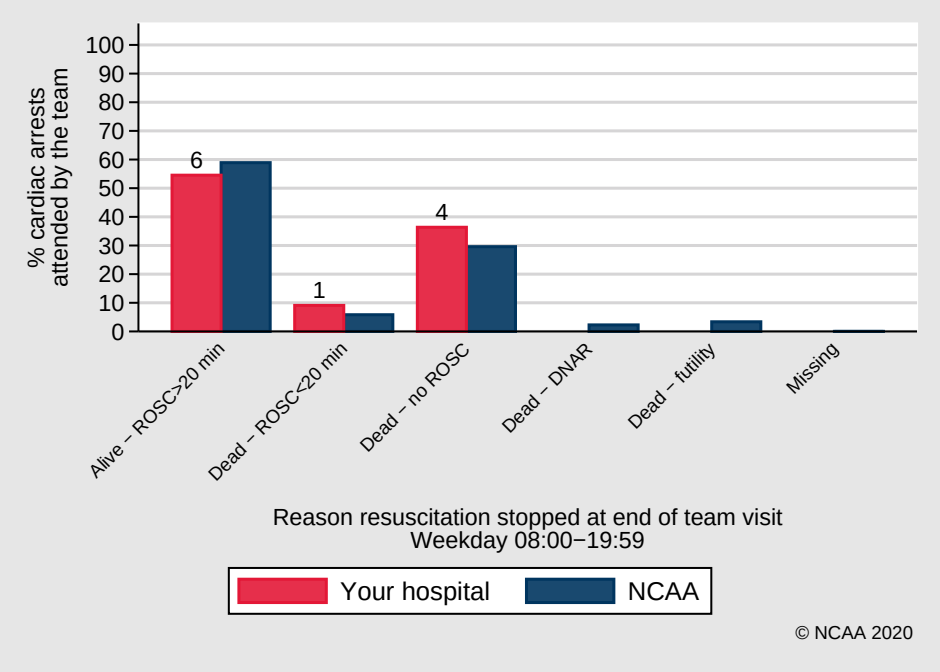
Reason resuscitation stopped at end of team visit for non-shockable - PEA



Reason resuscitation stopped at end of team visit for non-shockable - bradycardia

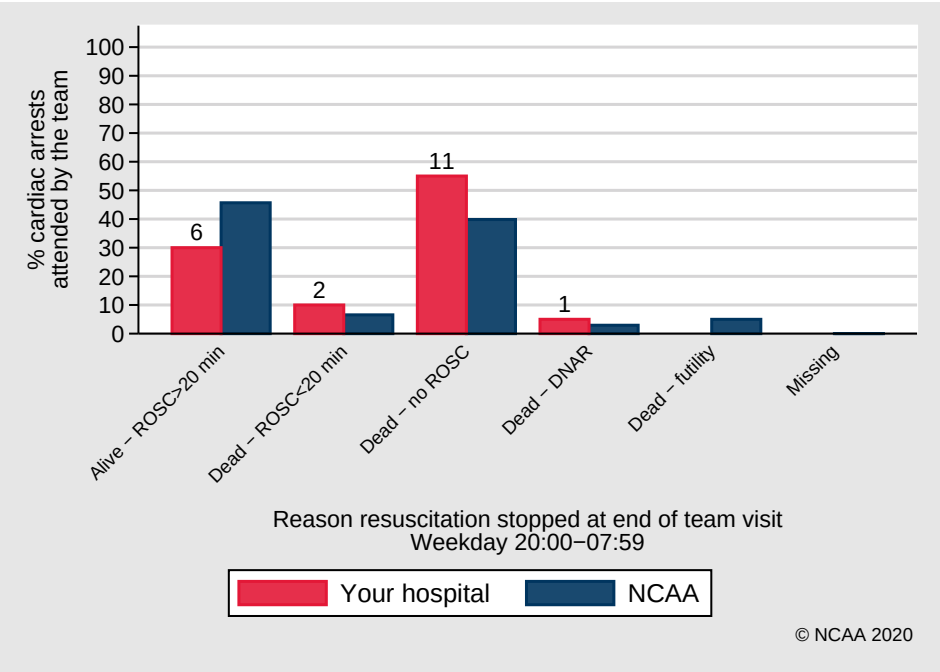


Reason resuscitation stopped at end of team visit by weekday 08:00-19:59



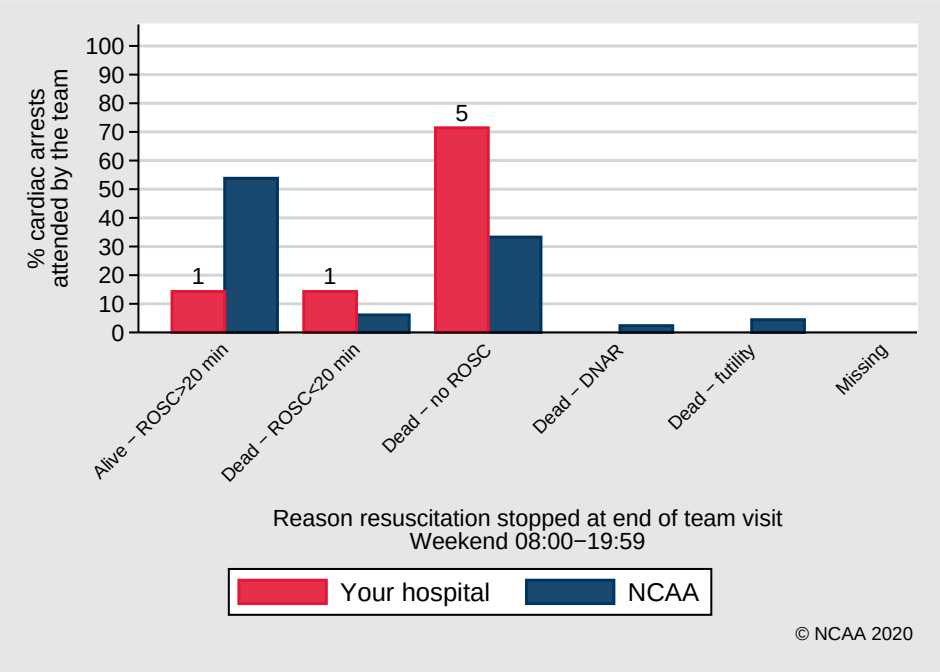
Weekday: Monday 08:00-Saturday 07:59

Reason resuscitation stopped at end of team visit by weekday 20:00-07:59



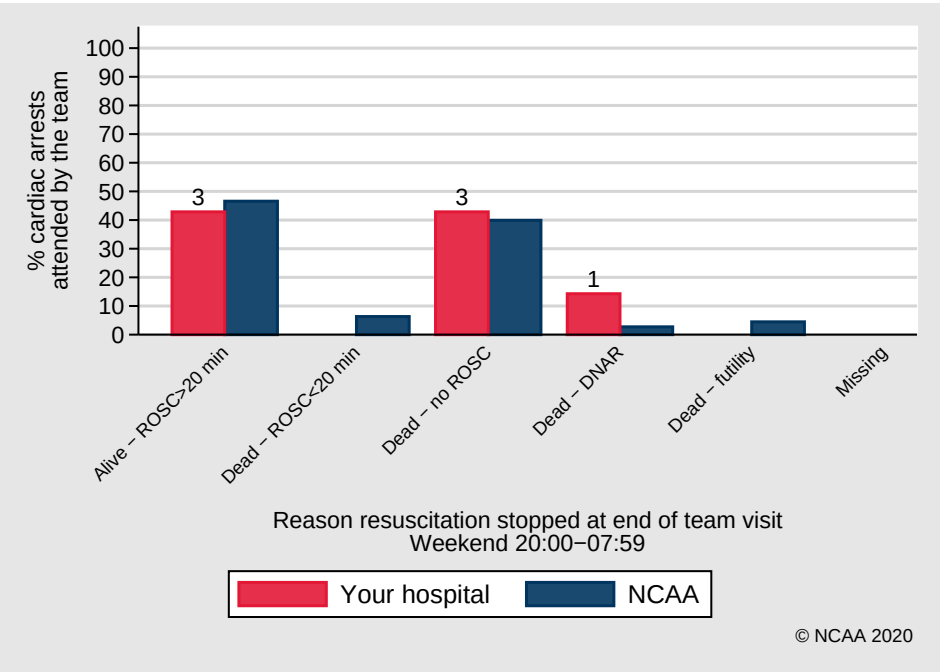
Weekday: Monday 08:00-Saturday 07:59

Reason resuscitation stopped at end of team visit by weekend 08:00-19:59



Weekend: Saturday 08:00-Monday 07:59

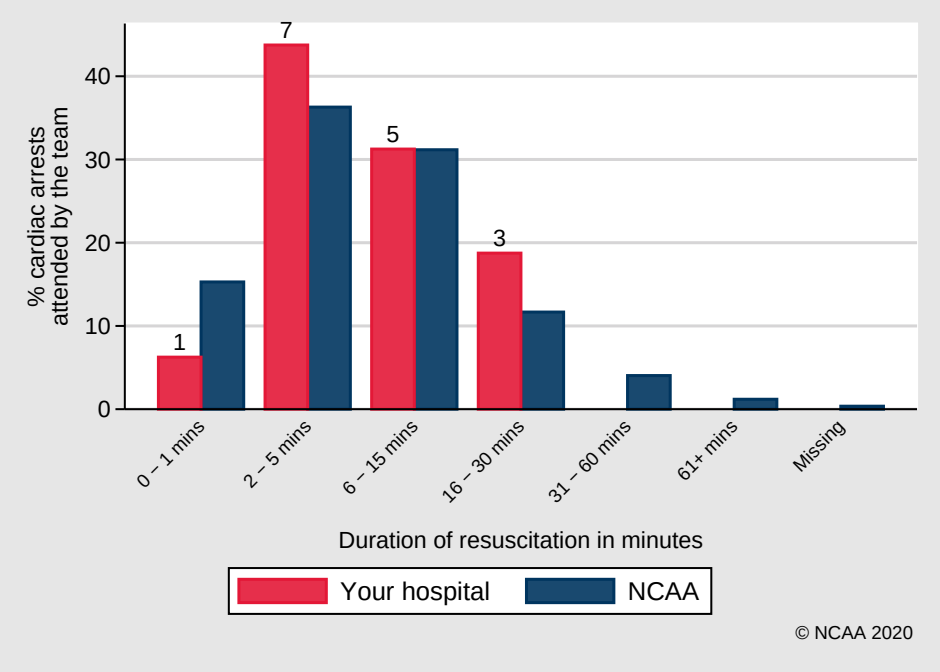
Reason resuscitation stopped at end of team visit by weekend 20:00-07:59



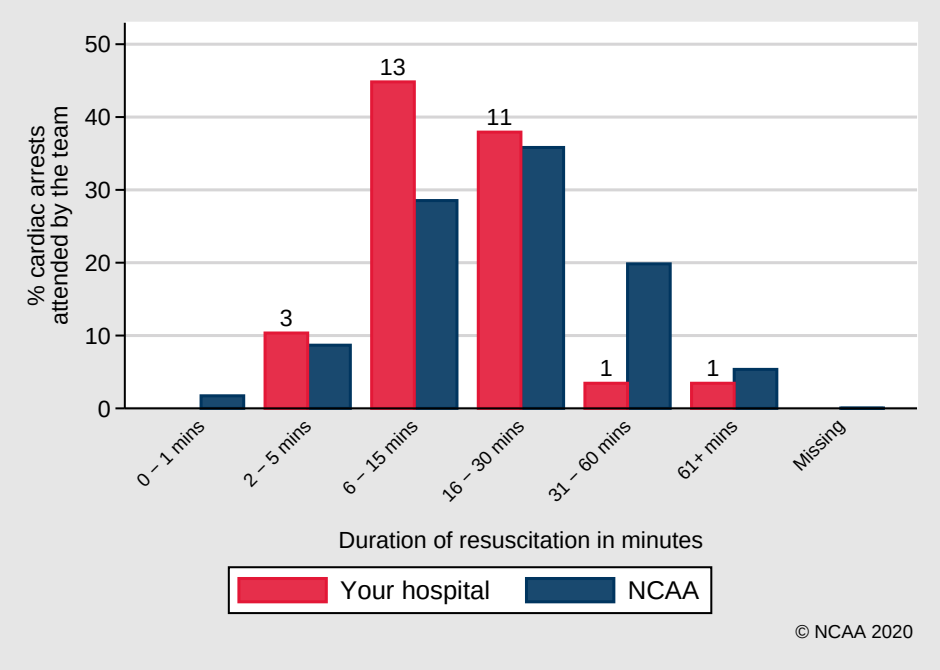
Weekend: Saturday 08:00-Monday 07:59

Duration of resuscitation

Duration of resuscitation (Alive - ROSC > 20mins)



Duration of resuscitation (Dead)



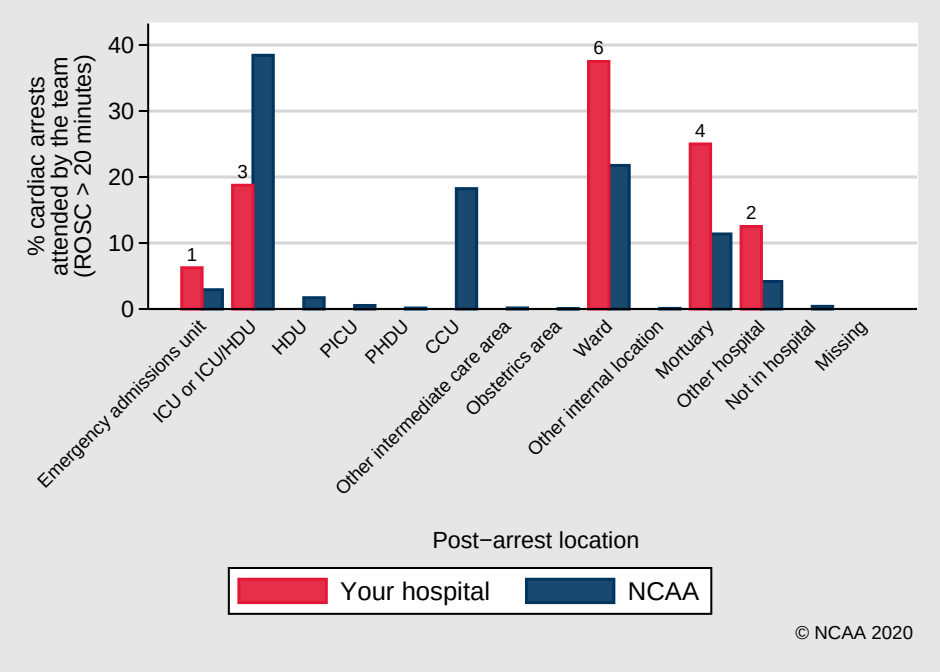
Potential non-arrests

Potential non-arrests based on the following criteria: presenting/first documented rhythm “Never determined”, duration of resuscitation less than or equal to 1 minute and reason resuscitation stopped “Alive - ROSC > 20 minutes”.

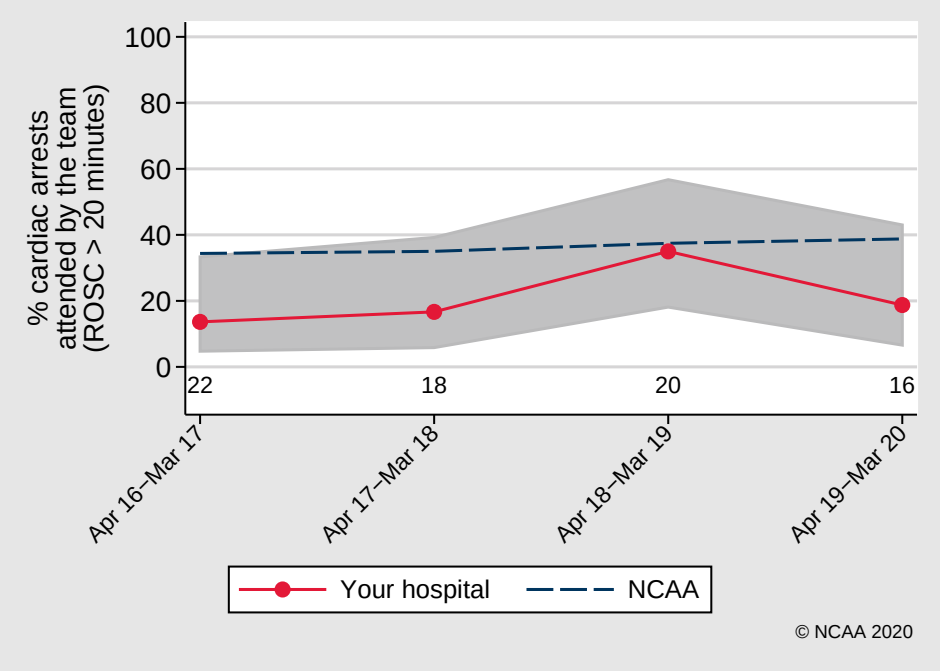
Team visit number	Date of team visit
20190019	08/05/2019

Post-arrest location

Post-arrest location

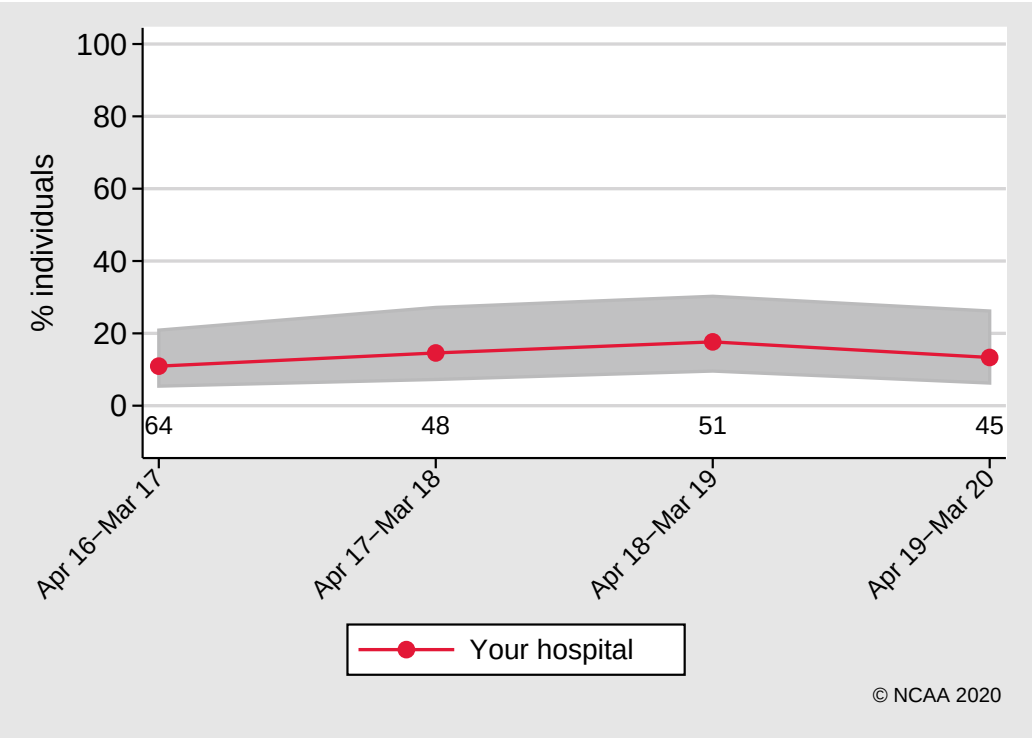


Post-arrest location (ICU or ICU/HDU) - trended



Status at hospital discharge

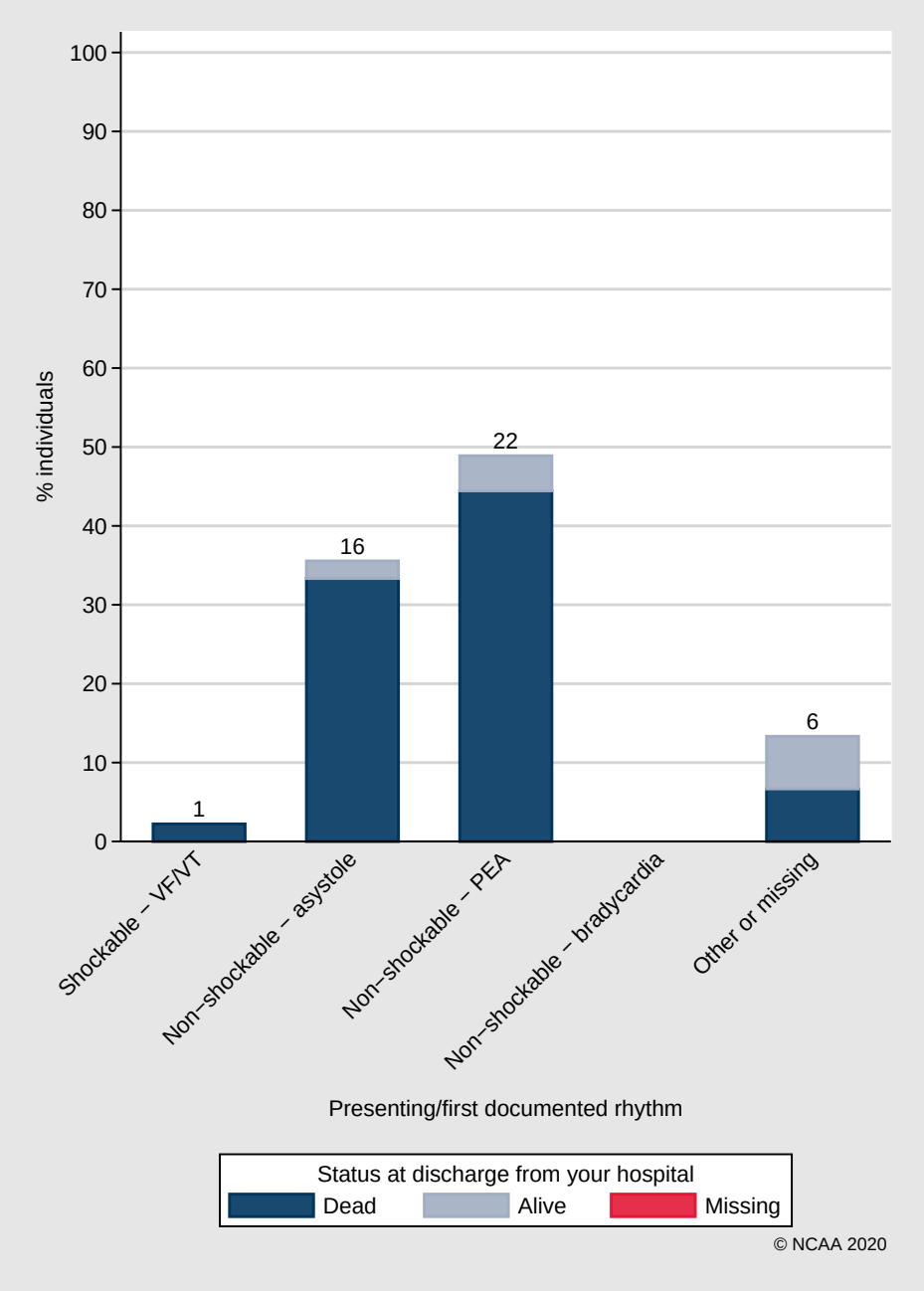
Status at hospital discharge (Alive) - trended



Note: NCAA comparator data are not plotted as these data are not risk adjusted

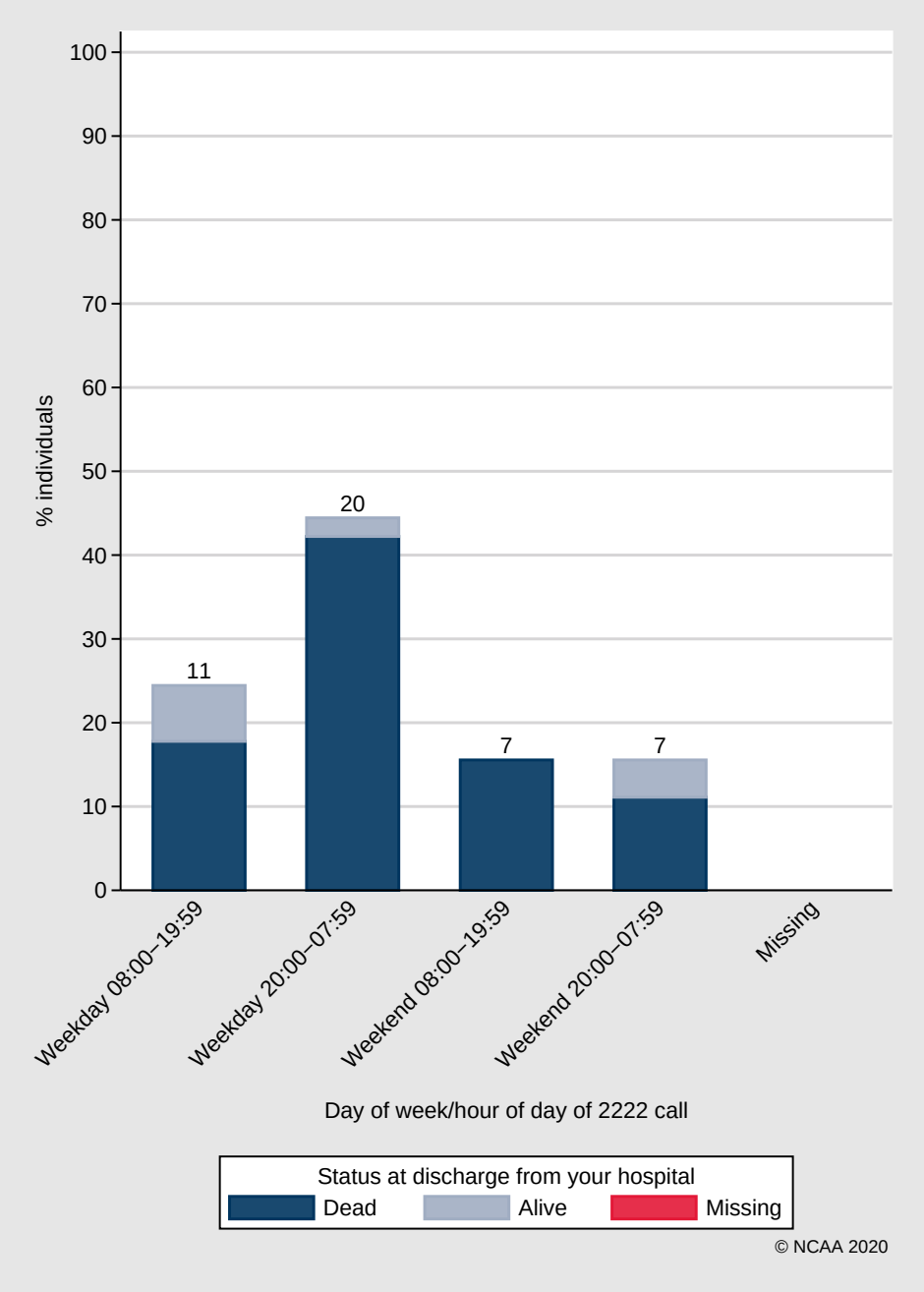
n = 0 individuals recorded as "patient still in your hospital" (excluded)

Status at hospital discharge by presenting/first documented rhythm



Note: n = 0 individuals recorded as ”patient still in your hospital” (excluded)

Status at hospital discharge by day of week/hour of day of 2222 call

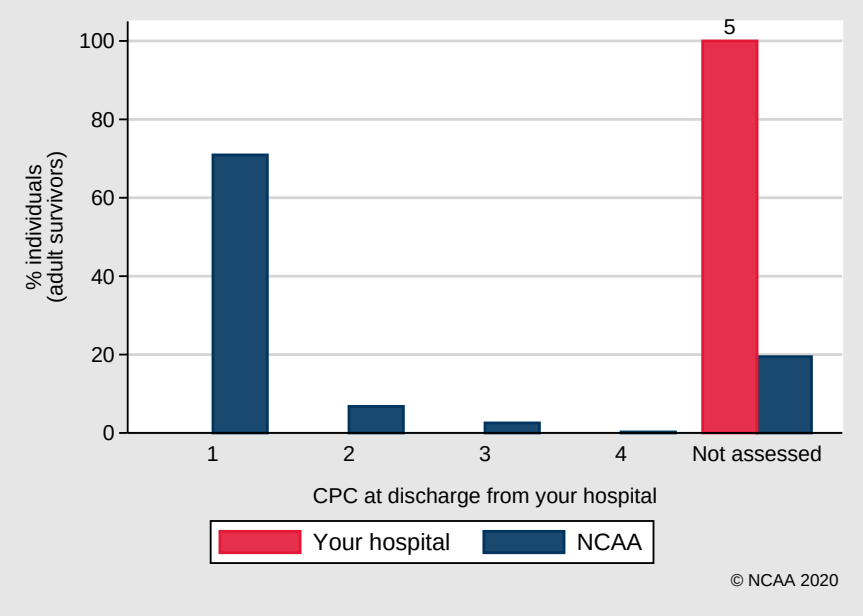


Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)

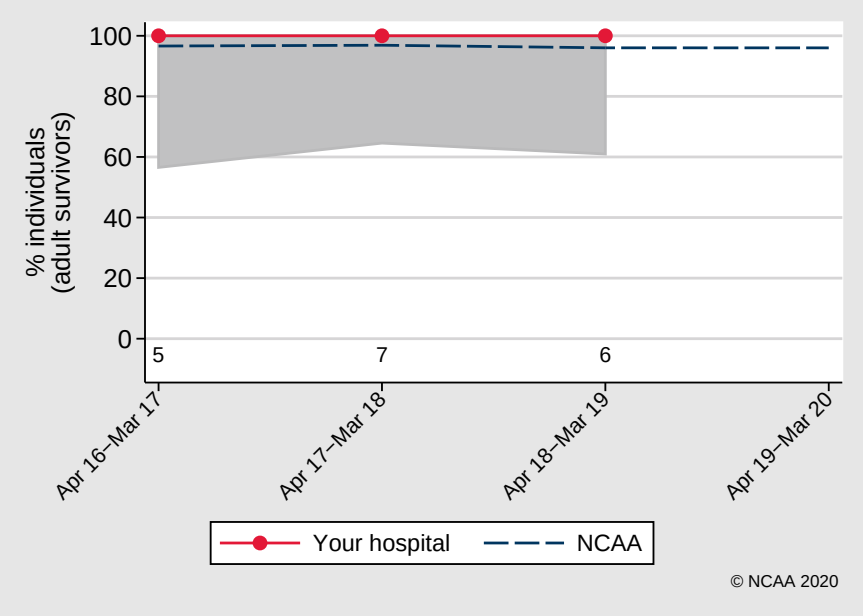
CPC at hospital discharge

CPC at discharge from your hospital: Adult survivors



Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)
n = 1 individuals sedated on discharge from your hospital (excluded)

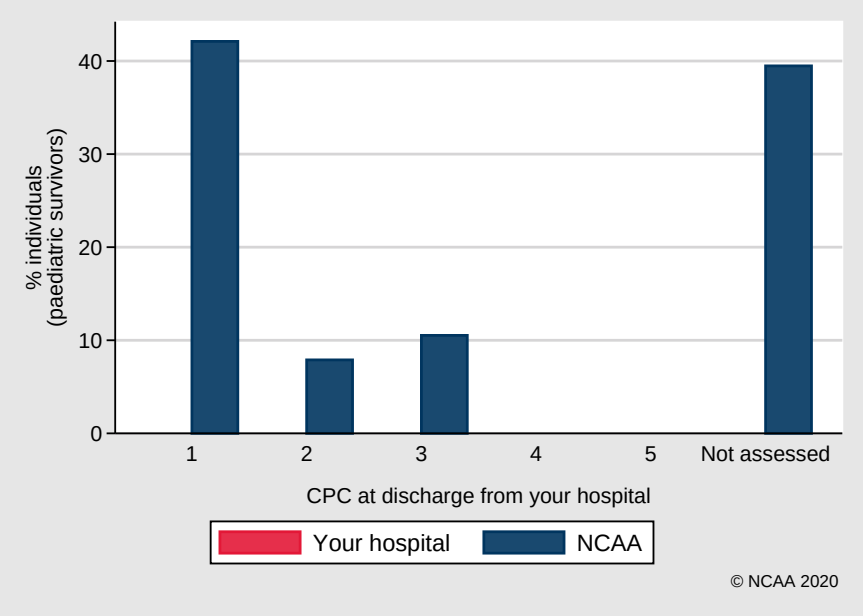
Favourable CPC at discharge from your hospital: Adult survivors - trended



Favourable neurological outcome is CPC 1 or 2 for adults

Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)
n = 1 individuals sedated on discharge from your hospital (excluded)

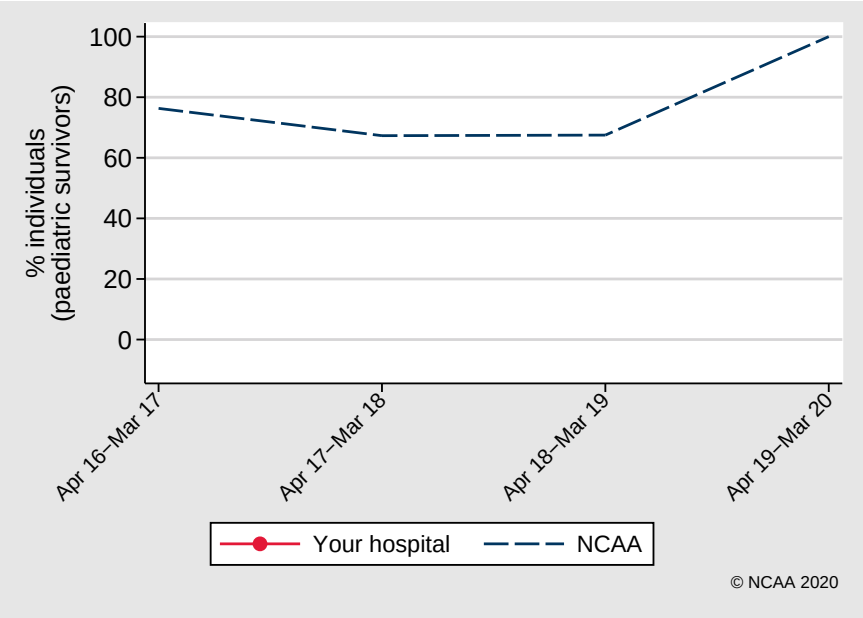
CPC at discharge from your hospital: Paediatric survivors (aged less than 16)



Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)

n = 0 individuals sedated on discharge from your hospital (excluded)

Favourable CPC at discharge from your hospital: Paediatric survivors (aged less than 16) - trended

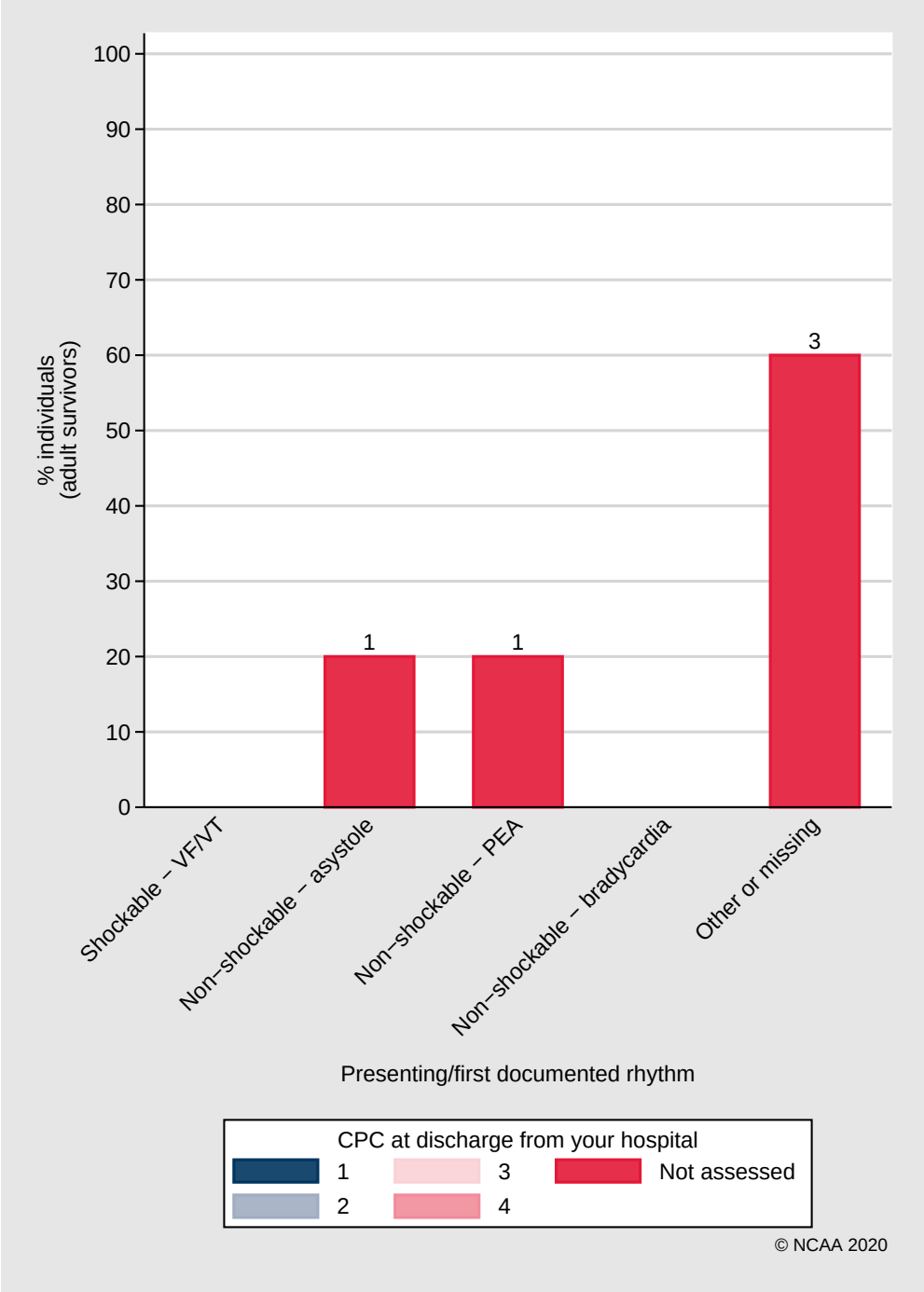


Favourable neurological outcome is CPC 1, 2 or 3 for paediatrics

Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)

n = 0 individuals sedated on discharge from your hospital (excluded)

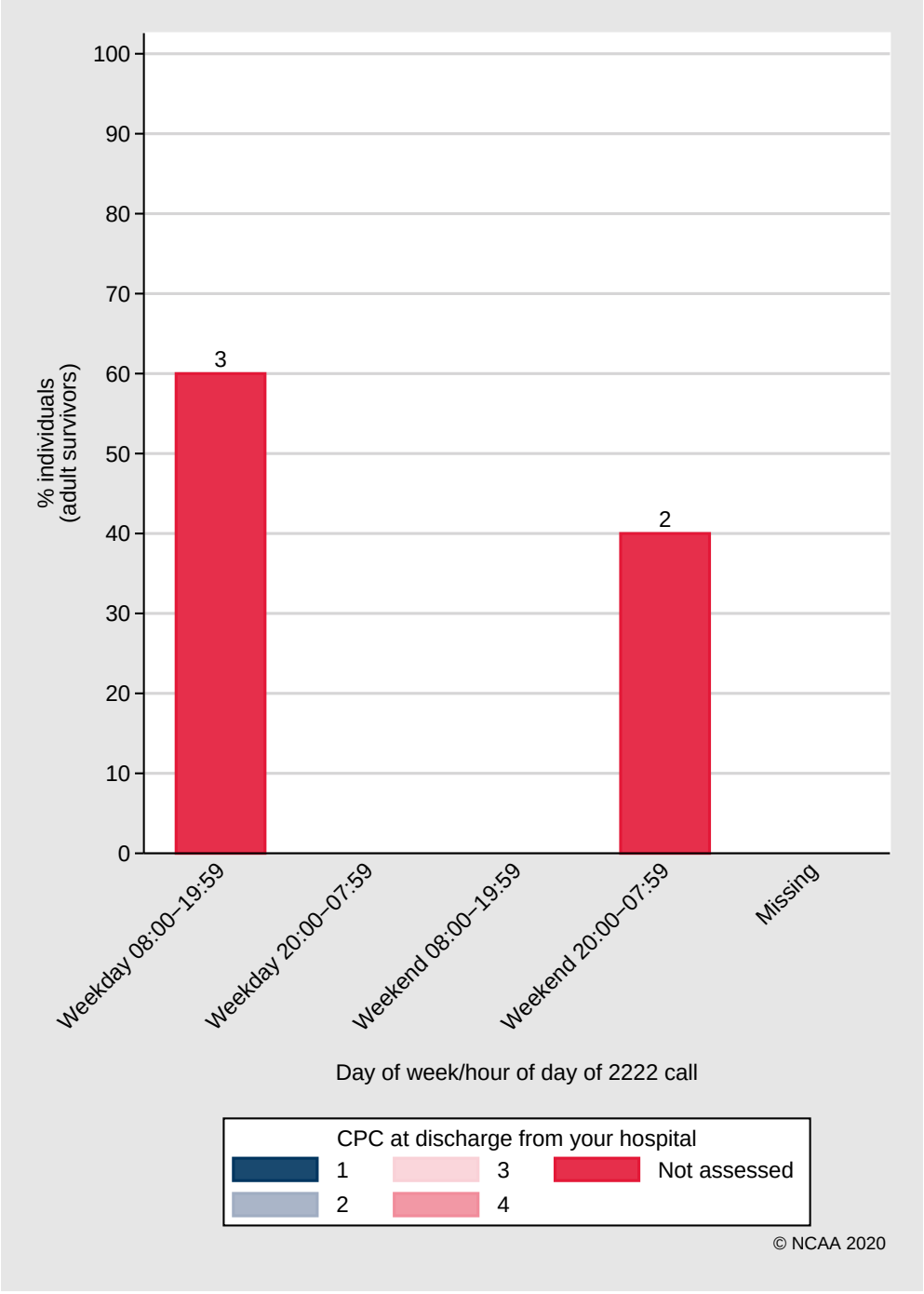
CPC at discharge from your hospital by presenting/first documented rhythm of first 2222 call: Adults



Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)

n = 1 individuals sedated on discharge from your hospital (excluded)

CPC at discharge from your hospital by day of week/hour of day of first 2222 call: Adults



Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

Note: n = 0 individuals recorded as "patient still in your hospital" (excluded)

n = 1 individuals sedated on discharge from your hospital (excluded)

Now review suggested questions for local use at the beginning of this section!

7. Stratified analyses

This section provides you with a stratified overview of in-hospital cardiac arrests attended by the team for your hospital against NCAA data for all adult, acute hospitals, for the period that this Report covers.

Stratified analyses provide grouped comparisons on specific outcome variables, including:

i. reason resuscitation stopped at end of team visit (Alive - ROSC>20 minutes) - reported as a percentage of cardiac arrests attended by the team;
ii. survival to hospital discharge - reported as a percentage of individuals; and
iii. favourable neurological outcome (CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics) at discharge from your hospital - reported as a percentage of individuals.

Stratified graphs for the outcomes listed above are presented under the following headings:

- age;
- day of week/hour of day of cardiac arrest attended by the team;
- location of arrest; and
- presenting/first documented rhythm.

Graphical presentation

Data for your hospital are plotted on each graph in red, and NCAA plotted in blue.

For each graph, the number of cardiac arrests attended by the team/individuals in each category for your hospital (for the period that this Report covers), is presented just above the x axis (horizontal).

Data points plotted are displayed with a 95% confidence interval (CI) shown as the vertical line through each data point (see image to left).

The values plotted are an estimate of the true underlying value because they are based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data provides a more accurate estimate of the value. Hence, the CI will become a narrower (shorter) vertical line. The CI, therefore, gives an indication of how accurately the value has been estimated. A 95% CI means that 95% of the time, we would expect the true value to lie along the vertical line.

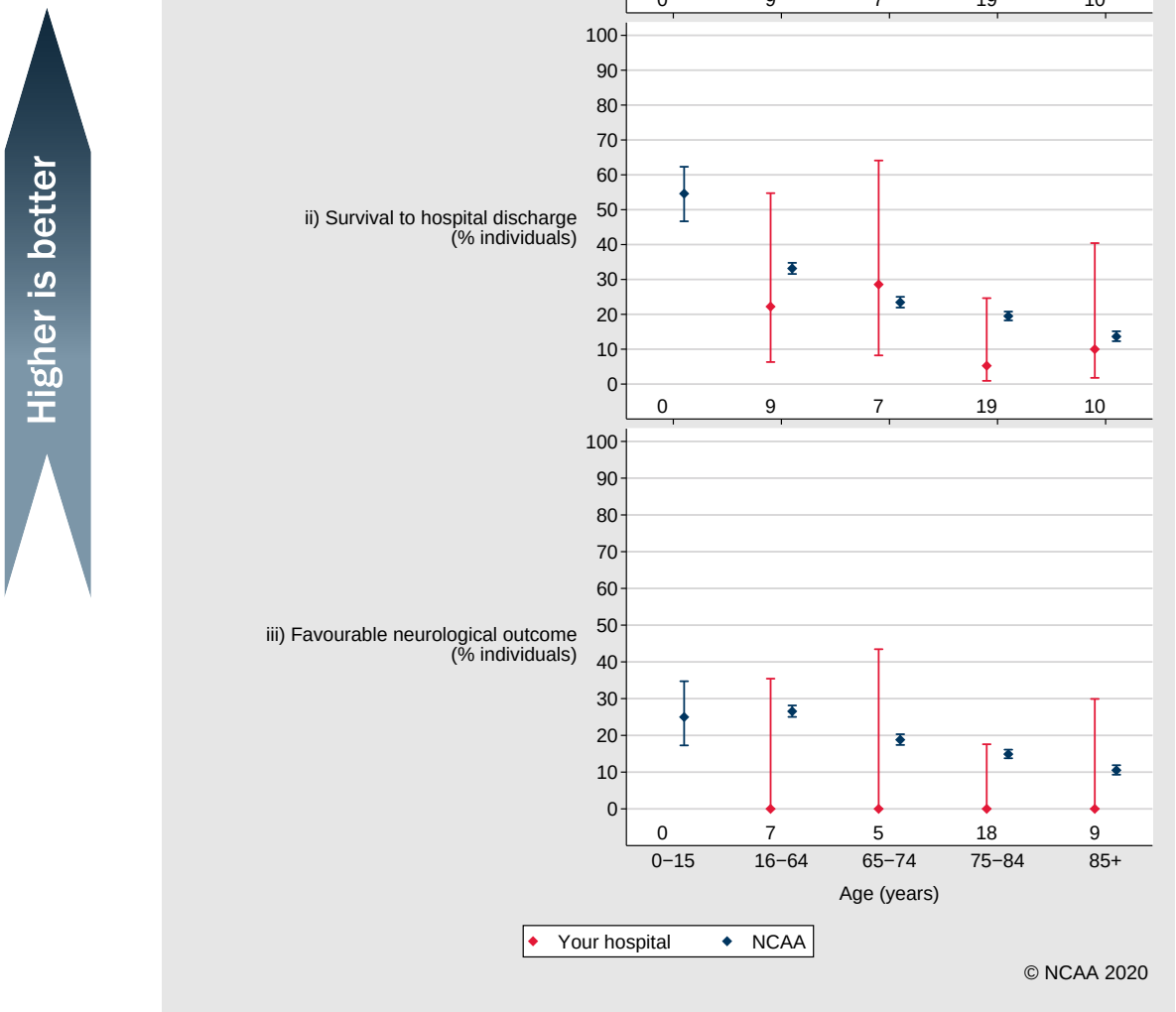
Note: where there are fewer than five cardiac arrests attended by the team/individuals in a category for your hospital, data are not plotted.

Suggested questions for local use

While interpreting the data in this section, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **How does your hospital compare with NCAA in terms of age; day of week/hour of day of cardiac arrest attended by the team; location of arrest; and presenting/first documented rhythm, for each outcome:**
  - **reason resuscitation stopped at end of team visit (Alive - ROSC>20 minutes);**
  - **survival to hospital discharge; and**
  - **favourable neurological outcome at discharge from your hospital.**
- **How could these stratified data be used for planning Resuscitation Team responses?**
- **How could these stratified data be used for wider service planning at your hospital?**

Outcomes by age



Favourable neurological outcome is CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics.

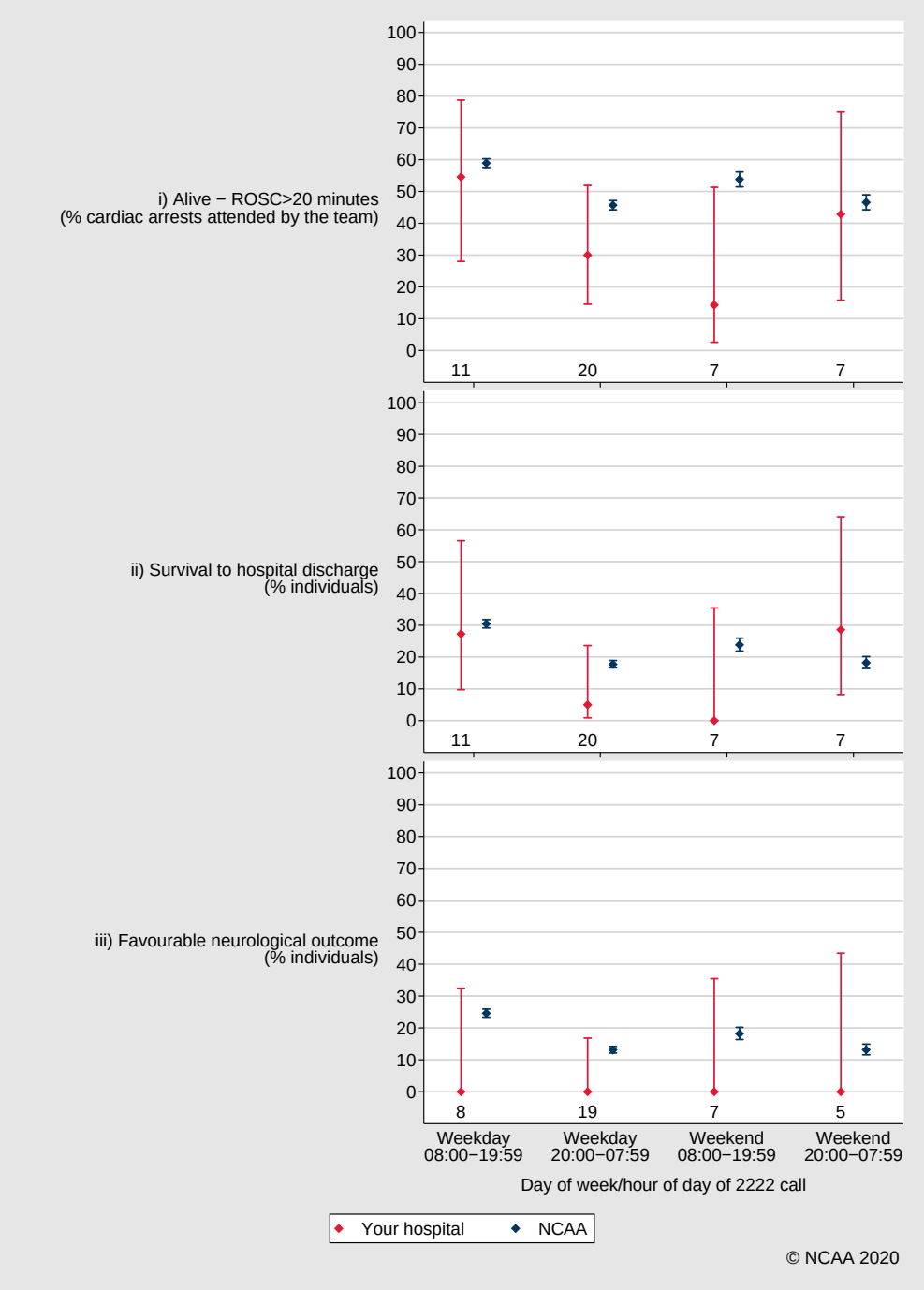
Note: n = 1 individuals sedated on discharge from your hospital (excluded)

n = 5 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)

n = 5 individuals recorded as ”patient still in your hospital” (excluded)

Outcomes by day of week/hour of day of cardiac arrest attended by the team

Higher is better



Favourable neurological outcome is CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics.

Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

Note: n = 1 individuals sedated on discharge from your hospital (excluded)

n = 5 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)

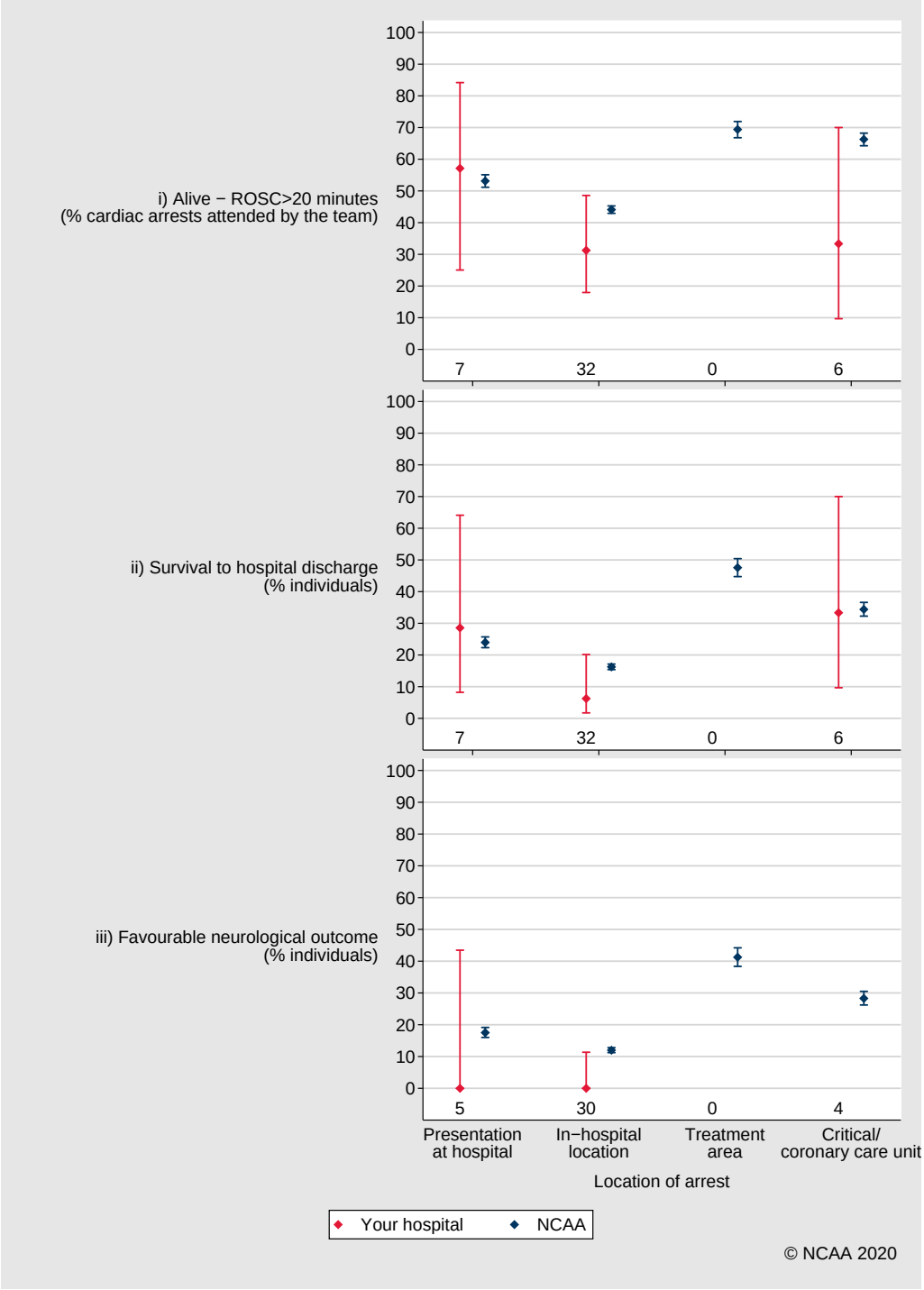
n = 5 individuals recorded as ”patient still in your hospital” (excluded)

Outcomes by location of arrest

For the graphs in this section, data for location of arrest have been grouped. Definitions of the categories on each graph:

- **Presentation at hospital:** Emergency department, emergency admissions unit (or equivalent), clinic, non-clinical area
- **In-hospital location:** Ward, obstetrics area, other intermediate care area, other internal location
- **Treatment area:** Theatre & recovery, imaging department, cardiac catheter laboratory, specialist treatment area
- **Critical/coronary care unit:** ICU or ICU/HDU, HDU, PICU, PHDU, CCU

Higher is better



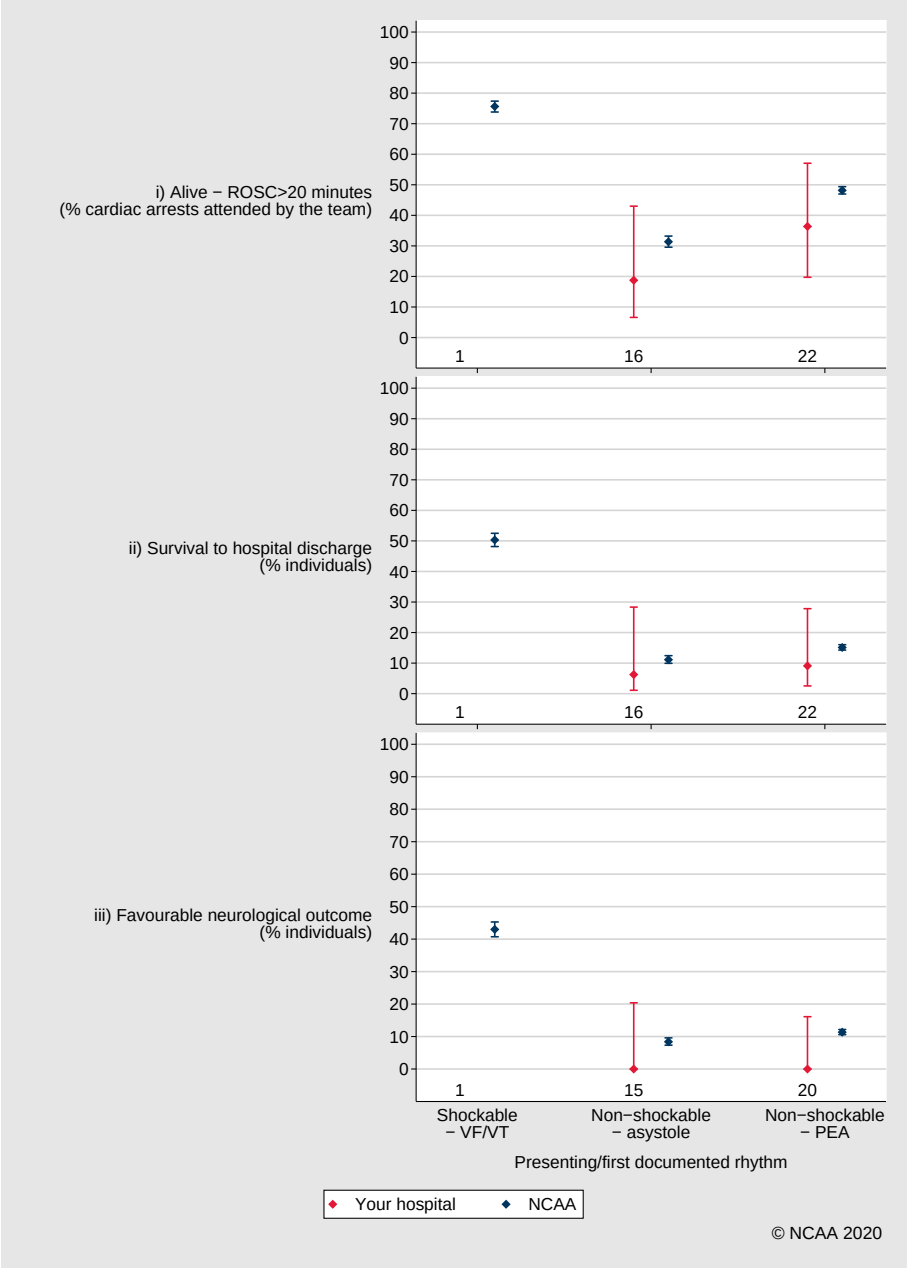
Favourable neurological outcome is CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics.

Note: n = 1 individuals sedated on discharge from your hospital (excluded)

n = 5 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)

n = 5 individuals recorded as "patient still in your hospital" (excluded)

Outcomes by presenting/first documented rhythm



Favourable neurological outcome is CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics.

Note: n = 1 individuals sedated on discharge from your hospital (excluded)

n = 2 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)

n = 2 individuals recorded as "patient still in your hospital" (excluded)

Now review suggested questions for local use at the beginning of this section!

8. Comparative analyses (non-risk adjusted)

This section provides you with basic comparative analyses on resuscitation outcomes for in-hospital cardiac arrests attended by the team for your hospital. These are not risk adjusted. Your hospital is compared with other adult, acute hospitals participating in NCAA.

The outcomes included in this section are survival to hospital discharge (reported as a percentage of individuals), by:

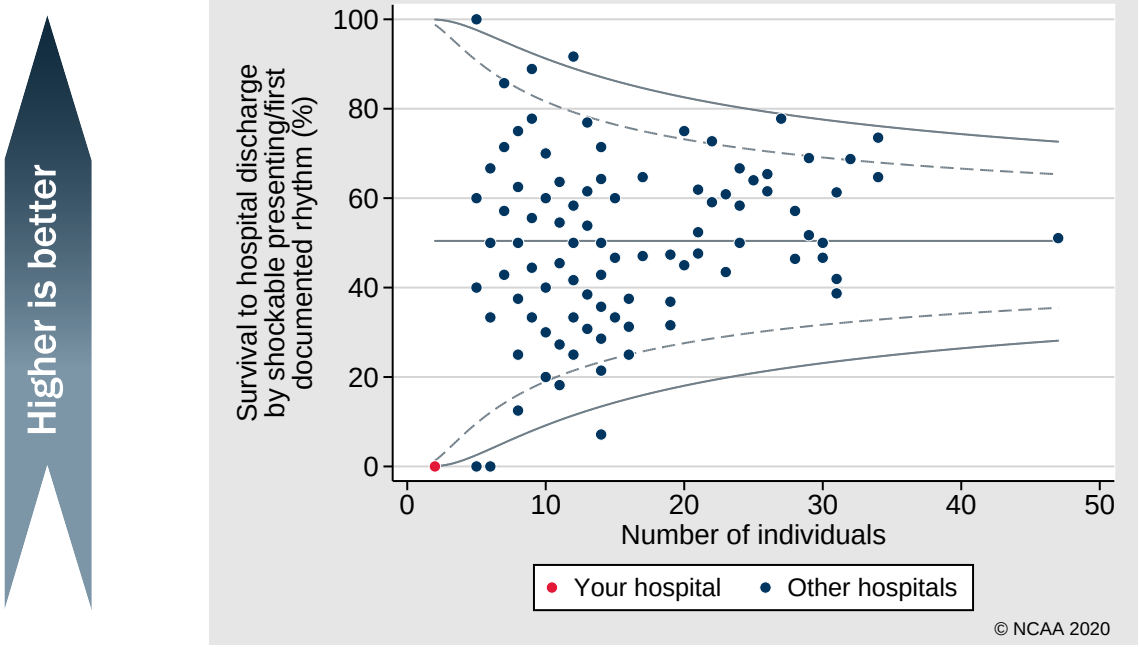
- shockable presenting/first documented rhythm; and
- non-shockable presenting/first documented rhythm.

Suggested questions for local use

While interpreting these non-risk adjusted comparative data, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **How do your non-risk adjusted outcomes compare with other NCAA participating hospitals?**
- **What other factors (e.g. age, etc.) might be causing the variation seen?**

Survival to hospital discharge by shockable presenting/first documented rhythm



Graphical presentation

The graph above shows the survival to hospital discharge by shockable presenting/first documented rhythm, plotted against number of individuals, at your hospital and other NCAA hospitals with at least five eligible individuals (for the period that this Report covers).

- **Red data point** = survival to hospital discharge by shockable presenting/first documented rhythm, for **your hospital**
- **Blue data points** = survival to hospital discharge by shockable presenting/first documented rhythm, for **other NCAA hospitals**

The percentage of individuals with a shockable presenting/first documented rhythm surviving to hospital discharge is presented on the y axis (vertical). The sample size (of the number of individuals) for hospitals is presented on the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point). The level of accuracy is indicated by the funnel lines on the graph.

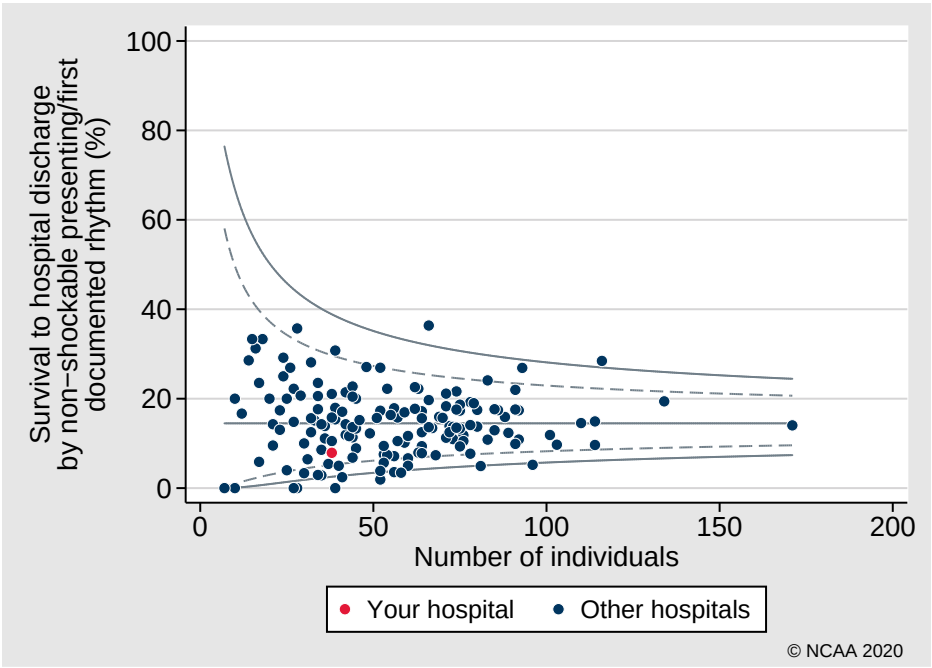
Standard deviation (SD) funnel lines

Standard deviation (SD) funnel lines on the graph are wider at lower sample sizes (i.e. fewer individuals) given the greater imprecision with small numbers, and narrower at higher sample sizes (i.e. higher number of individuals). Data points for higher sample sizes indicate a more accurate value.

If variation between hospitals is random (i.e. variation of results between hospitals is acceptable) then on average 95% of data points should lie within 2 SD (dashed funnel lines) and 99.8% should lie within 3 SD (solid funnel lines). Where data points lie outside of the funnel lines, this indicates that the variation of the results is **significant**.

Note: These data are not risk adjusted.

Survival to hospital discharge by non-shockable presenting/ first documented rhythm



Graphical presentation

The graph above shows the survival to hospital discharge by non-shockable presenting/first documented rhythm, plotted against number of individuals, at your hospital and other NCAA hospitals with at least five eligible individuals (for the period that this Report covers).

- **Red data point** = survival to hospital discharge by non-shockable presenting/first documented rhythm, for **your hospital**
- **Blue data points** = survival to hospital discharge by non-shockable presenting/first documented rhythm, for **other NCAA hospitals**

The percentage of individuals with a non-shockable presenting/first documented rhythm surviving to hospital discharge is presented on the y axis (vertical). The sample size (of the number of individuals) for hospitals is presented on the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point). The level of accuracy is indicated by the funnel lines on the graph.

Standard deviation (SD) funnel lines

Standard deviation (SD) funnel lines on the graph are wider at lower sample sizes (i.e. fewer individuals) given the greater imprecision with small numbers, and narrower at higher sample sizes (i.e. higher number of individuals). Data points for higher sample sizes indicate a more accurate value.

If variation between hospitals is random (i.e. variation of results between hospitals is acceptable) then on average 95% of data points should lie within 2 SD (dashed funnel lines) and 99.8% should lie within 3 SD (solid funnel lines). Where data points lie outside of the funnel lines, this indicates that the variation of the results is **significant**.

Note: These data are not risk adjusted.

Note that interpretation of these data is subject to:

- the inclusion of hospitals with data recorded for at least five individuals;
- an assumption that all hospitals are capturing data for presenting/first documented rhythm and outcome at hospital discharge accurately

Clearly, presenting rhythm is not the only determinant of survival and, were other risk factors (e.g. age, etc.) not similar across hospitals, survival rates could vary even within shockable/non-shockable rhythms. It is for this reason that a multivariable statistical risk model has been developed.

Risk adjusted comparative analyses, allowing fair and true comparisons to be made between participating hospitals, are presented in section 9.

Now review suggested questions for local use at the beginning of this section!

9. Risk adjusted comparative analyses

This section provides you with risk adjusted comparative analyses on resuscitation outcomes for in-hospital cardiac arrests attended by the team for your hospital.

Your data (for the period that this Report covers) are compared with all other NCAA participating hospitals (for the most recent twelve months of validated data).

Outcome data have been risk adjusted using multivariable statistical risk models developed by NCAA. The observed (i.e. actual) and predicted (as calculated by the NCAA risk model) outcomes are presented in this section and grouped by:

1) **ROSC greater than 20 minutes**
2) **Survival to hospital discharge**

Using these analyses, your hospital can fairly compare outcomes and identify whether patient outcomes at your hospital are within the bounds of what is expected compared with NCAA and other NCAA participating hospitals (this assumes that all team visits have been reported by your hospital).

NCAA risk modelling

The purpose of a risk model is to use data from prior to/at the start of an intervention (in this case the intervention of the Resuscitation Team) to predict the likelihood of an outcome.

NCAA risk models enable fair comparisons to be made between hospitals, whereby differences in the patient/event characteristics (e.g. age, presenting rhythm, etc.) that would be expected to result in differences in outcomes, are taken into account. The models were recalibrated in 2018, and are based on the following predictors -

- Age
- Sex
- Length of stay in hospital prior to arrest
- Reason for admission to/attendance at/visit to hospital
- Location of arrest
- Deteriorating (not yet arrested) at team arrival (for outcome hospital survival only)
- Presenting/first documented rhythm
- Interactions between location of arrest and presenting/first documented rhythm

The following are excluded from risk-adjusted comparative analyses:

- Revisits i.e. where an individual has had more than one visit from the hospital-based Resuscitation Team (or equivalent). In these cases, the first team visit is selected for analyses;
- Team visits which are missing outcome data;
- Team visits where the reason resuscitation stopped is recorded as Dead - DNAR; and
- Team visits which are missing one or more of the above predictors.

Period	01/04/2019 - 31/03/2020	
Total number of reported in-hospital team visits	45	
Team visit exclusions:	**ROSC>20mins**	**Survival to hospital discharge**
Revisits	0	0
Missing outcome	0	0
Outcome = Dead - DNAR	2	2
Missing predictors	0	0
Number of individuals included	43	43

Graphical presentation

Data for your hospital are plotted in red, and other participating hospitals/NCAA data are plotted in blue.

The results are presented by the following types of analyses:

- distribution of the predicted probability;
- calibration plot;
- funnel plot of observed to predicted outcomes;
- trended graph of observed to predicted outcomes (by quarter/six month periods/year, dependent on the sample size of data for your hospital); and
- EWMA (exponentially weighted moving average) plot - note that observed outcome is plotted in red and predicted outcome is plotted in blue.

Note: Trended graphs will be missing data points if a quarter/six month period/year is incomplete, either because that period contains unvalidated data or data was not submitted during that period.

Note that interpretation of these data is subject to:

- an assumption that all hospitals are capturing data for risk factors and outcomes accurately.

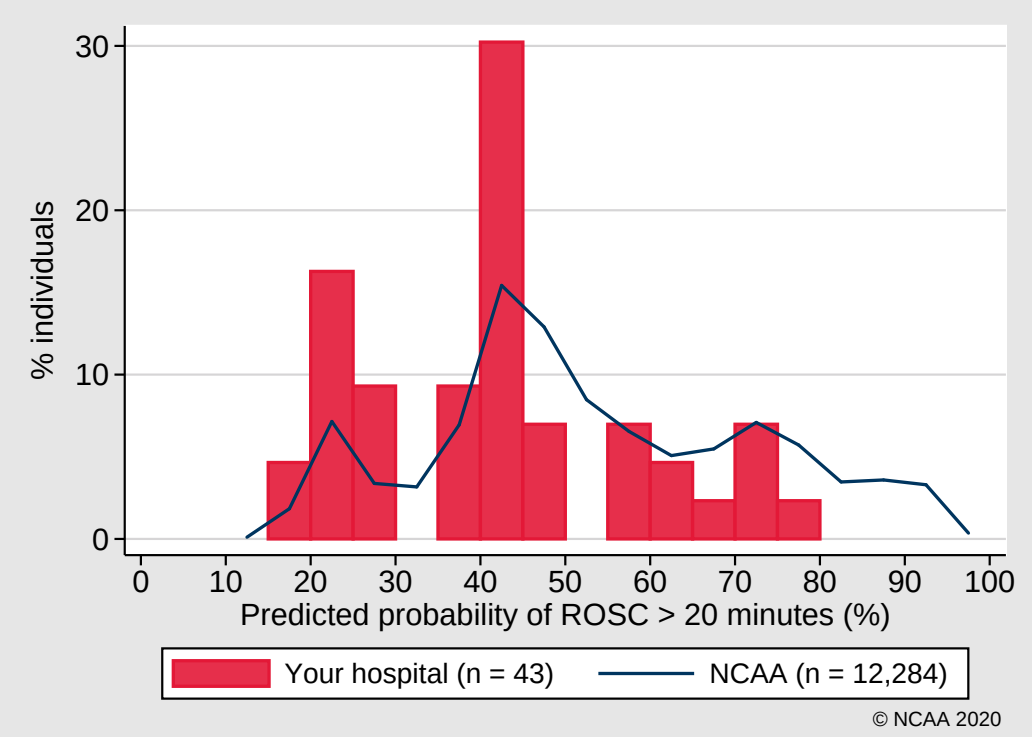
Suggested questions for local use

While interpreting these risk adjusted comparative data, it is important that the following specific questions are considered in order to maximise the use of your NCAA Report and bring about the implementation of change and quality improvement locally.

- **How do the observed outcomes at your hospital compare against the predicted outcomes at your hospital?**
- **Are there any trends in the observed to predicted (as calculated by the NCAA risk model(s)) outcome for patients at your hospital?**
- **Are there any unexpected results for the observed outcomes at your hospital?**
- **How do your outcomes compare with NCAA/other NCAA participating hospitals?**
- **How might your hospital improve outcomes following cardiac arrests attended by the team?**
- **Have quality improvement interventions at your hospital been successful?**
- **How could these risk adjusted comparative data be used for planning Resuscitation Team responses?**
- **How might you use these data to engage Clinicians, Managers, and Trust Board Members?**

ROSC greater than 20 minutes

Distribution of the predicted probability of ROSC > 20 minutes



Graphical presentation

The graph above shows the distribution of the predicted probability of ROSC > 20 minutes for individuals at your hospital (for the period that this Report covers) and NCAA (for the most recent twelve months of validated data).

- **Red bars** = predicted probability of ROSC > 20 minutes, for **your hospital**
- **Blue line** = predicted probability of ROSC > 20 minutes, for **NCAA**

The percentage of the predicted probability of ROSC > 20 minutes (calculated by the NCAA risk model) is presented in 5% groupings on the x axis (horizontal), and the percentage of individuals is presented on the y axis (vertical).

The sample size of the number of individuals for your hospital and NCAA is shown in the legend on the graph.

Questions

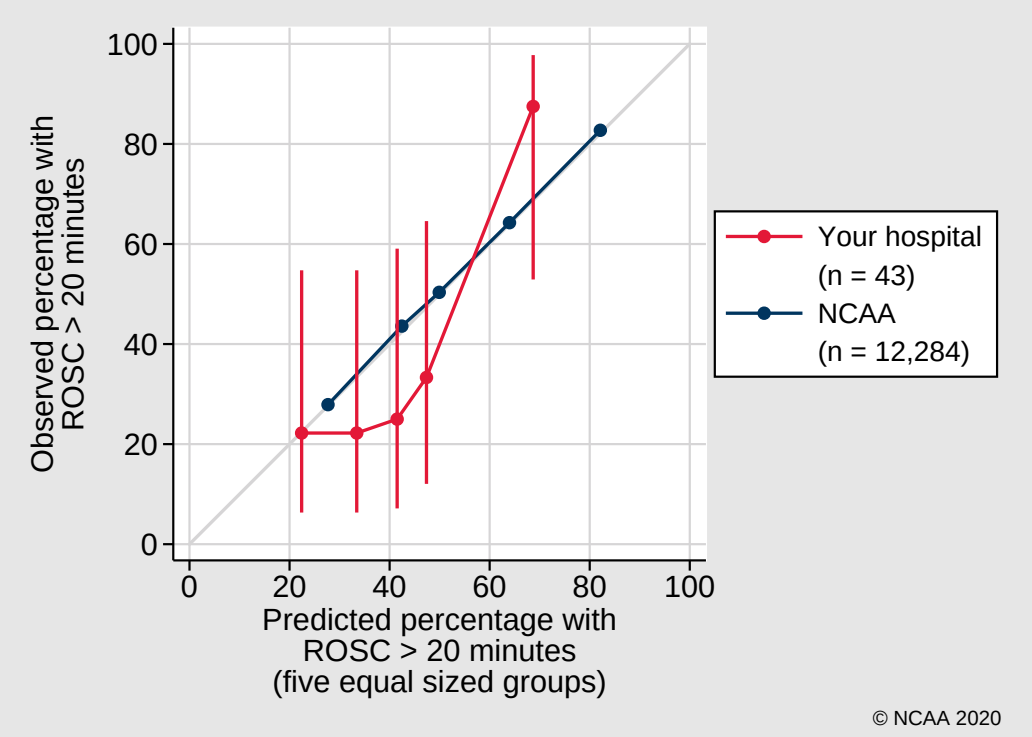
What is the percentage of individuals (y axis (vertical) for each 5% grouping of predicted probability of ROSC > 20 minutes (x axis (horizontal)) at your hospital? How does the distribution vary for your hospital?

- For each 5% grouping of predicted probability of ROSC > 20 minutes (0%- 5%, 5%-10%, 10%-15%, etc.) on the x axis (horizontal), follow the red bar to the top and read the value on the y axis (vertical).

How does the distribution of the predicted probability of ROSC > 20 minutes at your hospital compare to NCAA?

- For each grouping of predicted probability (0%-5%, 5%-10%, 10%-15%, etc.) on the x axis (horizontal), continue in a straight line upwards to the blue line and read the value on the y axis (vertical)
- Compare values (on the y axis (vertical)) for your hospital (red bar) and NCAA (blue line) for the same 5% grouping (x axis (horizontal) and overall.

Calibration plot for ROSC > 20 minutes



Graphical presentation

The plot above shows the observed percentage with ROSC > 20 minutes against the predicted percentage with ROSC > 20 minutes, for five equal sized groups (where each group must have at least five team visits) of individuals (patients) at your hospital (for the period that this Report covers) and NCAA (for the most recent twelve months of validated data).

- **Red data points**= observed against the predicted percentage with ROSC > 20 minutes for a group of individuals, for **your hospital**
- **Blue data points**= observed against the predicted percentage with ROSC > 20 minutes for a group of individuals, for **NCAA**

The five equal sized groups of individuals are formed by ordering the data for individuals by their predicted probability of ROSC > 20 minutes (low to high) as calculated by the NCAA risk model. These ordered data are then divided into the five equal sized groups (count five data points for your hospital and NCAA on the plot). Note: to be plotted on the calibration plot each group must have at least five team visits.

Each data point plots the observed (i.e. actual) percentage with ROSC > 20 minutes (y axis (vertical)) against the predicted percentage with ROSC > 20 minutes (x axis (horizontal)), for each group of individuals, for your hospital and NCAA.

Data points for NCAA show that the observed percentage is similar to the predicted probability percentage with ROSC > 20 minutes for each group of individuals, which indicates the accuracy of the NCAA risk model for predicting the probability of ROSC > 20 minutes.

Data point lies:

- **ON** the bold grey diagonal line across the plot, this indicates that the observed percentage with ROSC > 20 minutes is **equal** to the predicted for that group of individuals.
- **ABOVE** (i.e. to the left of) the bold grey diagonal line across the plot, this indicates that the observed percentage with ROSC > 20 minutes is **higher** than predicted for that group of individuals.
- **BELOW** (i.e. to the right of) the bold grey diagonal line across the plot, this indicates that the observed percentage with ROSC > 20 minutes is **lower** than predicted for that group of individuals.

Data points plotted for your hospital are displayed with a 95% confidence interval (CI) shown as the vertical line through each data point (see image to the left).

These data points plotted are an estimate of the true underlying value because it is based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data provides a more accurate estimate of the value. Hence, the CI will become a narrower (shorter) vertical line. The CI, therefore, gives an indication of how accurately the value has been estimated. A 95% CI means that 95% of the time, we would expect the true value to lie along the vertical line.

The sample size of the number of individuals for your hospital and NCAA is shown in the legend on the graph.

Questions

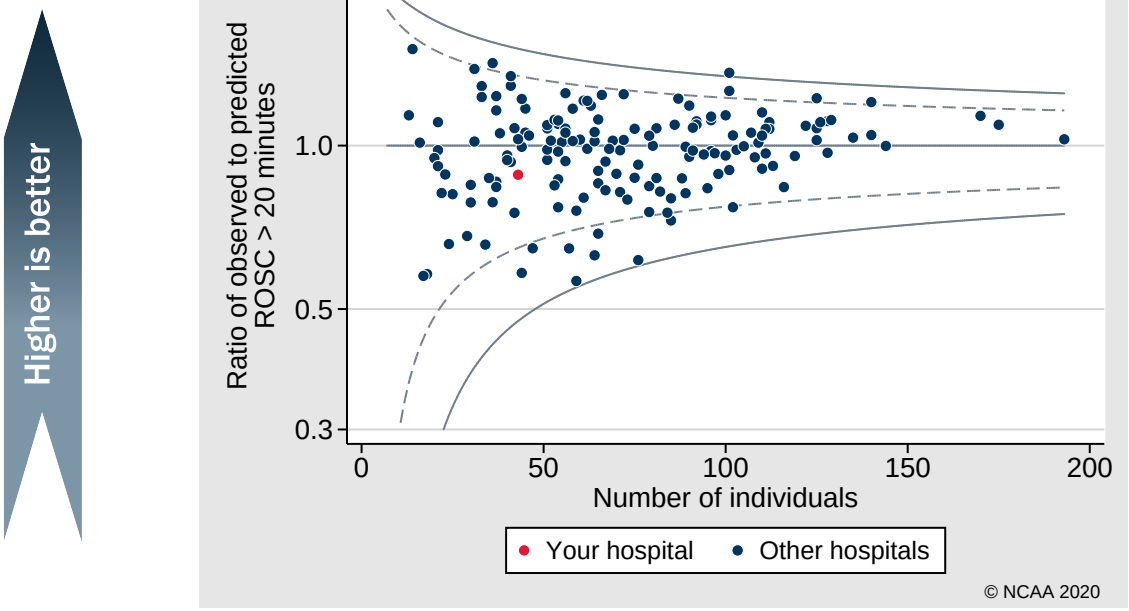
Is the observed percentage with ROSC > 20 minutes higher or lower than the predicted percentage with ROSC > 20 minutes for each equal sized group of individuals at your hospital? What could be the reason(s) for any differences?

- For each data point (i.e. each equal sized group of individuals) for your hospital (red), read the value on the x axis (horizontal) for the predicted percentage with ROSC > 20 minutes and then the value on the y axis (vertical) for the observed percentage with ROSC > 20 minutes.
- Compare the value for the predicted and observed percentage with ROSC > 20 minutes for each data point for your hospital.

For each equal sized group of individuals, how does the observed percentage with ROSC > 20 minutes against the predicted percentage with ROSC > 20 minutes at your hospital compare to NCAA?

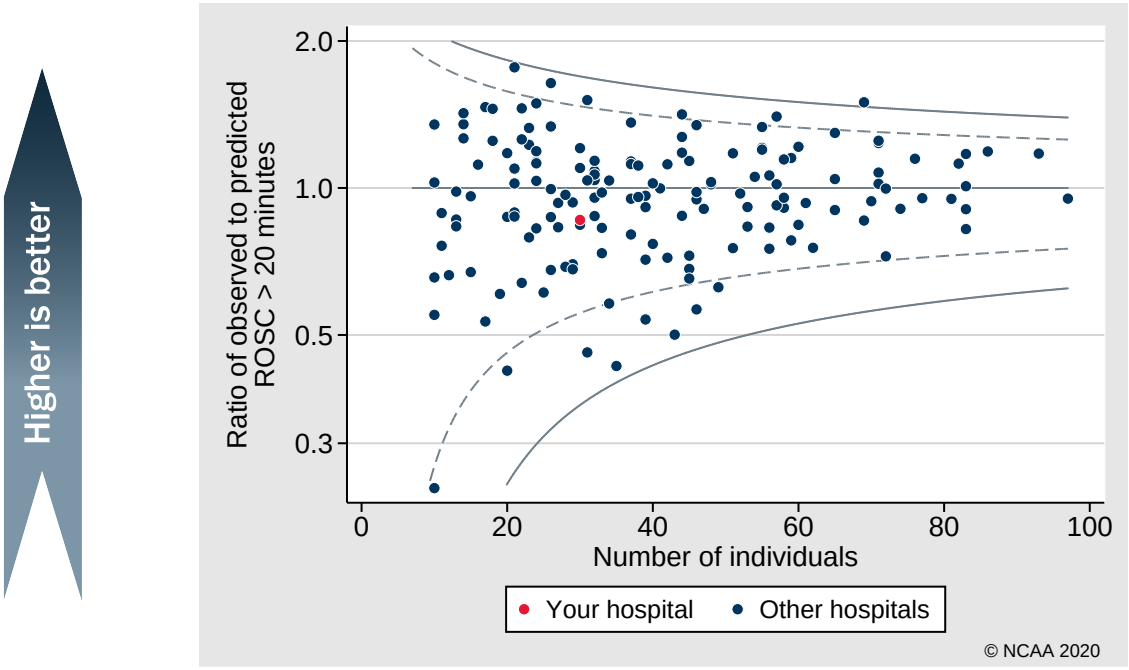
- Read the values for each data point for your hospital (red) as per the steps above and compare this against the data point for NCAA (blue).

Funnel plot of observed to predicted ROSC > 20 minutes



Your hospital	
Number of individuals	43
Number of individuals with observed ROSC > 20 minutes	16
Number of individuals with predicted ROSC > 20 minutes	18.1
Ratio of observed to predicted ROSC > 20 minutes	0.88
95% confidence interval	(0.58,1.24)

Funnel plot of observed to predicted ROSC > 20 minutes for arrests on the ward



Your hospital	
Number of individuals with arrests on the ward	30
Number of individuals with observed ROSC > 20 minutes	10
Number of individuals with predicted ROSC > 20 minutes	11.6
Ratio of observed to predicted ROSC > 20 minutes	0.86
95% confidence interval	(0.50,1.32)

Graphical presentation

The plot above shows the ratio of observed to predicted ROSC > 20 minutes plotted against number of individuals, for your hospital (for the period that this Report covers) and other NCAA hospitals with at least ten eligible individuals (for the most recent twelve months of validated data).

- **Red data point** = ratio of observed to predicted ROSC > 20 minutes, for **your hospital**
- **Blue data points** = ratio of observed to predicted ROSC > 20 minutes, for **other NCAA hospitals**

The ratio of observed (i.e. actual) to predicted ROSC > 20 minutes is presented on the y axis (vertical). It is calculated by dividing the number of individuals with ROSC > 20 minutes (i.e. observed) by the number of individuals predicted (as calculated by the NCAA risk model) to have ROSC > 20 minutes.

Explanations of ratios (y axis (vertical)) in relation to where a data point sits on the plot:

- **Ratio is 1.0** - observed ROSC > 20 minutes is **equal** to the predicted ROSC > 20 minutes i.e. the number of individuals to have ROSC > 20 minutes was the same as predicted
- **Ratio is greater than 1.0** - observed ROSC > 20 minutes is **higher** than the predicted ROSC > 20 minutes i.e. more individuals had ROSC > 20 minutes than predicted
- **Ratio is less than 1.0** - observed ROSC > 20 minutes is **lower** than the predicted ROSC > 20 minutes i.e. less individuals had ROSC > 20 minutes than predicted

The sample size (of the number of individuals) for hospitals is presented on the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point). The level of accuracy is indicated by the funnel lines on the plot.

Standard deviation (SD) funnel lines

Standard deviation (SD) funnel lines on the plot are wider at lower sample sizes (i.e. fewer individuals) given the greater imprecision with small numbers, and narrower at higher sample sizes (i.e. higher number of individuals). Data points for higher sample sizes indicate a more accurate value.

If variation between hospitals is random (i.e. variation of results between hospitals is acceptable) then on average 95% of data points should lie within 2 SD (dashed funnel lines) and 99.8% should lie within 3 SD (solid funnel lines). Where data points lie outside of the funnel lines, this indicates that the variation of the results is **significant**.

Values presented in the table

The exact ratio for the observed to predicted ROSC > 20 minutes for your hospital is presented in the table. Data points are estimates, therefore 95% confidence interval values are also provided in the table indicating the range of values likely to contain the true value.

Questions

What is the ratio for the observed ROSC > 20 minutes to the predicted ROSC > 20 minutes for your hospital?

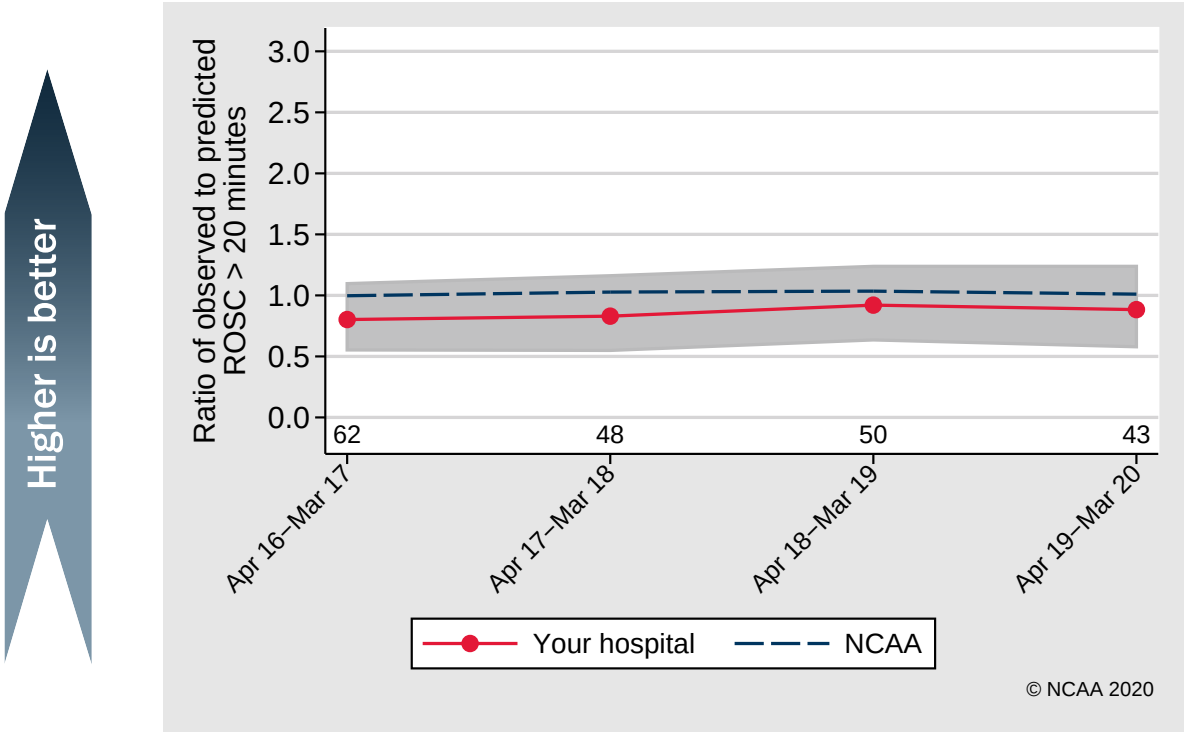
- Read the ratio for your hospital (red data point) on the y axis (vertical).
  Note: the exact ratio for your hospital is specified in the table beneath the graph. Ratios are explained earlier in this section.
- As data points are estimates, the 95% confidence interval values provided in the table, indicate the range of values likely to contain the true value for your hospital.

Where does the red data point for your hospital lie within the funnel, and how does it compare to other NCAA hospitals (blue data points)?

Data point lies:

- **WITHIN** funnel lines - observed ROSC > 20 minutes is **not significantly different** from predicted.
- **ABOVE** funnel lines - observed ROSC > 20 minutes is **significantly higher** than predicted.
- **BELOW** funnel lines - observed ROSC > 20 minutes is **significantly lower** than predicted.

Trend of observed to predicted ROSC > 20 minutes



Graphical presentation

The graph above shows the trend over time by quarter for the ratio of observed to predicted ROSC > 20 minutes, at your hospital and NCAA.

- **Red data points and line** = ratio of observed to predicted ROSC > 20 minutes, for **your hospital**
- **Blue line** = ratio of observed to predicted ROSC > 20 minutes, for **NCAA**

The ratio of observed (i.e. actual) to predicted ROSC > 20 minutes is presented on the y axis (vertical). It is calculated by dividing the number of individuals with ROSC > 20 minutes (i.e. observed) by the number of individuals predicted (as calculated by the NCAA risk model) to have ROSC > 20 minutes.

Explanations of ratios (y axis (vertical)):

- **Ratio is 1.0** - observed ROSC > 20 minutes is **equal** to the predicted ROSC > 20 minutes i.e. the number of individuals to have ROSC > 20 minutes was the same as predicted
- **Ratio is greater than 1.0** - observed ROSC > 20 minutes is **higher** than the predicted ROSC > 20 minutes i.e. more individuals had ROSC > 20 minutes than predicted
- **Ratio is less than 1.0** - observed ROSC > 20 minutes is **lower** than the predicted ROSC > 20 minutes i.e. less individuals had ROSC > 20 minutes than predicted

Periods of data over time (by quarter) are presented on the x axis (horizontal). The sample size for each period for your hospital is presented just above the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point).

The grey shaded area of the graph represents the 95% confidence interval (CI). Each data point plotted for your hospital is an estimate of the true underlying value because it is based on a certain sized sample of data. The true value will most likely lie somewhere within the shaded area.

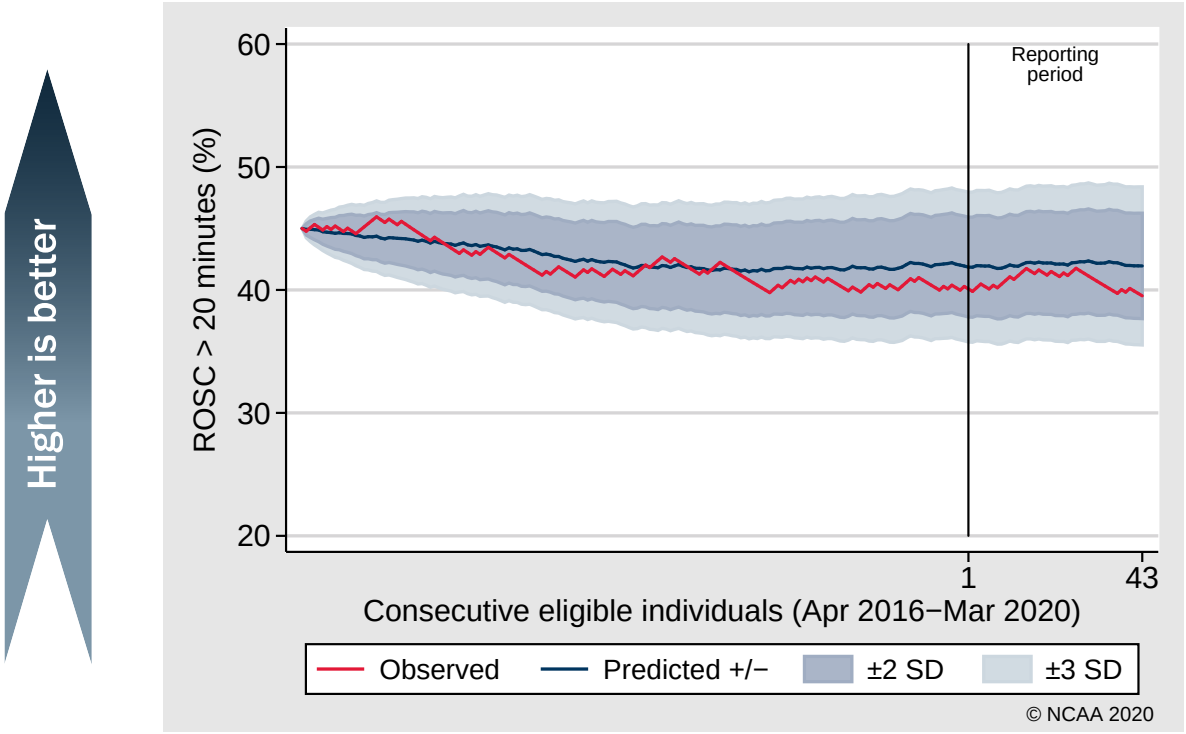
A large sample of data provides a more accurate estimate of the value. Hence, the shaded area will become a narrower. The CI, therefore, gives an indication of how accurately the value has been estimated.

Questions

Is the ratio of the observed (i.e. actual) to the predicted ROSC > 20 minutes at your hospital greater, less than, or equal to 1.0, over time? Can you see any trend or variation? What could be the reason(s) for this?

- Read the ratio for each red data point for your hospital on the y axis (vertical). Ratios are explained earlier in this section.
- As data points are estimates, the 95% confidence interval values provided in the table, indicate the range of values likely to contain the true value for your hospital.

EWMA plot for ROSC > 20 minutes



Graphical presentation

The EWMA (exponentially weighted moving average) plot above shows the observed and predicted ROSC > 20 minutes for consecutive individuals at your hospital, for the period that this Report covers and historically.

- **Red line** = average **observed** (i.e. actual) percentage with ROSC > 20 minutes, for your hospital
- **Blue line** = average **predicted** percentage with ROSC > 20 minutes, for your hospital

Values plotted are averages for the observed percentage with ROSC > 20 minutes at your hospital and predicted (as calculated by the NCAA risk model) percentage with ROSC > 20 minutes for your hospital. Both are presented on the y axis (vertical). The original NCAA risk model is used for individuals prior to April 2018 and the 2018 recalibration for individuals from April 2018 onwards.

Consecutive individuals are shown on the x axis (horizontal). As the sample size increases with each consecutive (additional) individual reported by your hospital, the EWMA sequentially plots the updated values. Consecutive individuals are 'exponentially weighted' - giving a larger weighting in favour of the most recent individuals, smoothing the appearance of the lines.

The vertical black line indicates the start of the period that this Report covers. Values plotted before the vertical black line show historical data for your hospital.

2 SD and 3 SD

The blue shaded areas of the plot (graph) represent 2 and 3 standard deviations (SD) above and below the predicted line (blue).

If variation over time is random then on average 95% of values plotted should lie within 2 SD (dark blue shaded area) and 99.8% should lie within 3 SD (light blue shaded area).

- If the observed ROSC >20 minutes line (red) is **ABOVE and outside of the blue shaded areas**, this means that the observed percentage with ROSC > 20 minutes for your hospital is **significantly higher** than the predicted percentage with ROSC > 20 minutes.
  i.e. significantly more individuals achieved ROSC > 20 minutes than predicted.
- If the observed ROSC >20 minutes line (red) is **BELOW and outside of the blue shaded areas**, this means that observed percentage with ROSC > 20 minutes for your hospital is **significantly lower** than the predicted percentage with ROSC > 20 minutes.
  i.e. significantly less individuals achieved ROSC > 20 minutes than predicted.

Questions

What is the average observed percentage with ROSC > 20 minutes at your hospital, at the end of this reporting period? How does this compare to the predicted percentage with ROSC > 20 minutes at your hospital?

- Read the value plotted at the end of the red line on the y axis (vertical).
- Read the value plotted at the end of the blue line on the y axis (vertical).
- Compare these values.

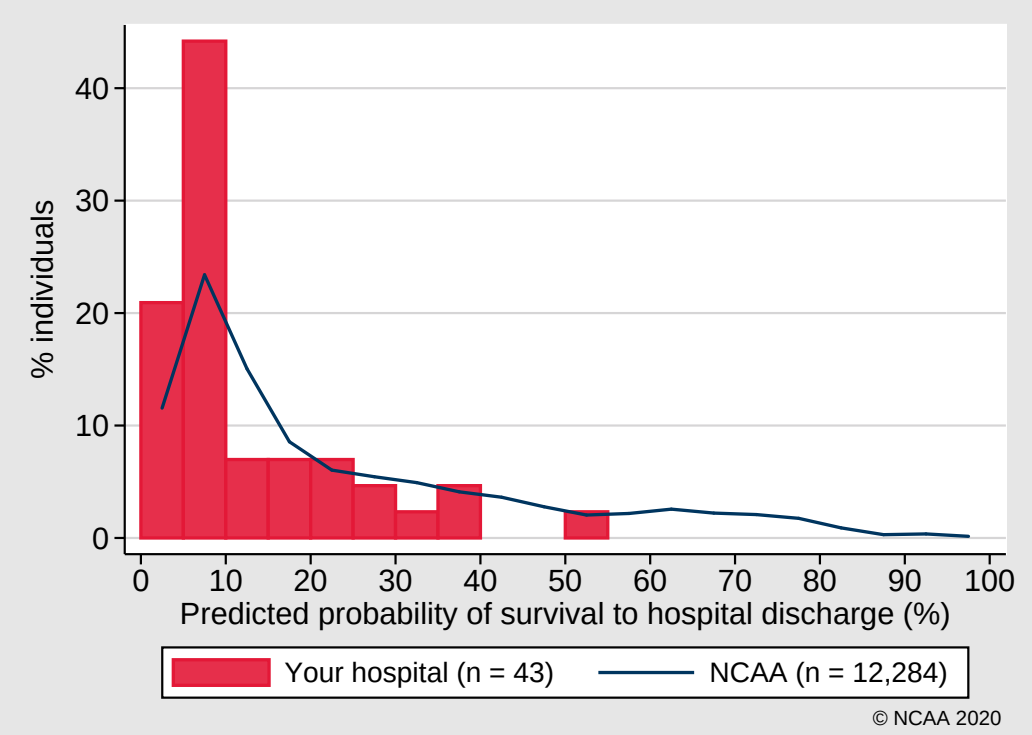
Are there any variations in the average observed percentage with ROSC > 20 minutes against the predicted percentage with ROSC > 20 minutes over time, at your hospital?

- Assess the differences between value plotted for the red line (observed) and the blue line (predicted) across the whole graph (i.e. from where the red and blue lines begin).

The significance of the difference between the value plotted for observed and predicted ROSC > 20 minutes is indicated by the 2 and 3 standard deviation (SD) shaded areas (see earlier explanation).

Survival to hospital discharge

Distribution of the predicted probability of survival to hospital discharge



Graphical presentation

The graph above shows the distribution of the predicted probability of survival to hospital discharge for individuals at your hospital (for the period that this Report covers) and NCAA (for the most recent twelve months of validated data).

- **Red bars** = predicted probability of survival to hospital discharge, for **your hospital**
- **Blue line** = predicted probability of survival to hospital discharge, for **NCAA**

The percentage of the predicted probability of survival to hospital discharge (calculated by the NCAA risk model) is presented in 5% groupings on the x axis (horizontal), and the percentage of individuals is presented on the y axis (vertical).

The sample size of the number of individuals for your hospital and NCAA is shown in the legend on the graph.

Questions

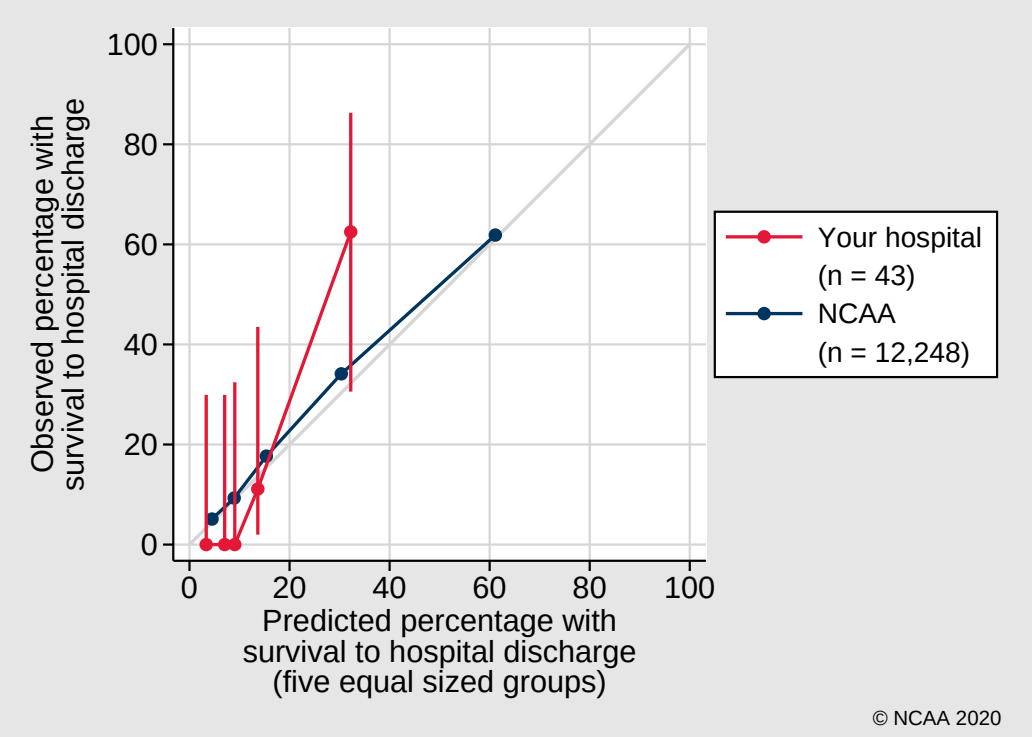
What is the percentage of individuals (y axis (vertical) for each 5% grouping of predicted probability of survival to hospital discharge (x axis (horizontal)) at your hospital? How does the distribution vary for your hospital?

- For each 5% grouping of predicted probability of survival to hospital discharge (0%- 5%, 5%-10%, 10%-15%, etc.) on the x axis (horizontal), follow the red bar to the top and read the value on the y axis (vertical).

How does the distribution of the predicted probability of survival to hospital discharge at your hospital compare to NCAA?

- For each grouping of predicted probability (0%-5%, 5%-10%, 10%-15%, etc.) on the x axis (horizontal), continue in a straight line upwards to the blue line and read the value on the y axis (vertical)
- Compare values (on the y axis (vertical)) for your hospital (red bar) and NCAA (blue line) for the same 5% grouping (x axis (horizontal) and overall.

Calibration plot for survival to hospital discharge



Graphical presentation

The plot above shows the observed percentage of survival to hospital discharge against the predicted percentage of survival to hospital discharge, for five equal sized groups (where each group must have at least five team visits) of individuals (patients) at your hospital (for the period that this Report covers) and NCAA (for the most recent twelve months of validated data).

- **Red data points** = observed against the predicted percentage of survival to hospital discharge for a group of individuals, for **your hospital**
- **Blue data points** = observed against the predicted percentage of survival to hospital discharge for a group of individuals, for **NCAA**

The five equal sized groups of individuals are formed by ordering the data for individuals by their predicted probability of survival to hospital discharge (low to high) as calculated by the NCAA risk model. These ordered data are then divided into the five equal sized groups (count five data points for your hospital and NCAA on the plot). Note: to be plotted on the calibration plot each group must have at least five team visits.

Each data point plots the observed (i.e. actual) percentage of survival to hospital discharge (y axis (vertical)) against the predicted percentage of survival to hospital discharge (x axis (horizontal)), for each group of individuals, for your hospital and NCAA.

Data points for NCAA show that the observed percentage is similar to the predicted probability percentage of survival to hospital discharge for each group of individuals, which indicates the accuracy of the NCAA risk model for predicting the probability of survival to hospital discharge.

Data point lies:

- **ON** the bold grey diagonal line across the plot, this indicates that the observed percentage of survival to hospital discharge is **equal** to the predicted for that group of individuals.
- **ABOVE** (i.e. to the left of) the bold grey diagonal line across the plot, this indicates that the observed percentage of survival to hospital discharge is **higher** than predicted for that group of individuals.
- **BELOW** (i.e. to the right of) the bold grey diagonal line across the plot, this indicates that the observed percentage of survival to hospital discharge is **lower** than predicted for that group of individuals.

Data points plotted for your hospital are displayed with a 95% confidence interval (CI) shown as the vertical line through each data point (see image to the left).

These data points plotted are an estimate of the true underlying value because it is based on a certain sized sample of data. The true value will most likely lie somewhere along the vertical line of the CI.

A large sample of data provides a more accurate estimate of the value. Hence, the CI will become a narrower (shorter) vertical line. The CI, therefore, gives an indication of how accurately the value has been estimated. A 95% CI means that 95% of the time, we would expect the true value to lie along the vertical line.

The sample size of the number of individuals for your hospital and NCAA is shown in the legend on the graph.

Questions

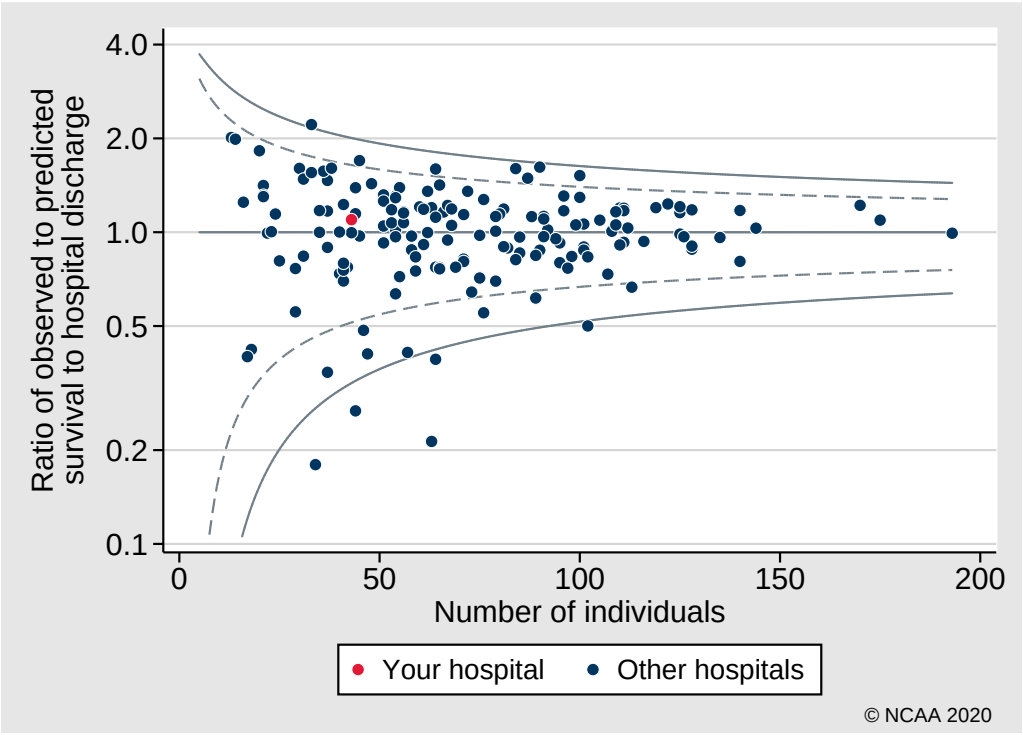
Is the observed percentage of survival to hospital discharge higher or lower than the predicted percentage of survival to hospital discharge for each equal sized group of individuals at your hospital? What could be the reason(s) for any differences?

- For each data point (i.e. each equal sized group of individuals) for your hospital (red), read the value on the x axis (horizontal) for the predicted percentage of survival to hospital discharge and then the value on the y axis (vertical) for the observed percentage of survival to hospital discharge.
- Compare the value for the predicted and observed percentage of survival to hospital discharge for each data point for your hospital.
- Refer to the table listing unexpected non-survivors at the end of this section

For each equal sized group of individuals, how does the observed percentage of survival to hospital discharge against the predicted percentage of survival to hospital discharge at your hospital compare to NCAA?

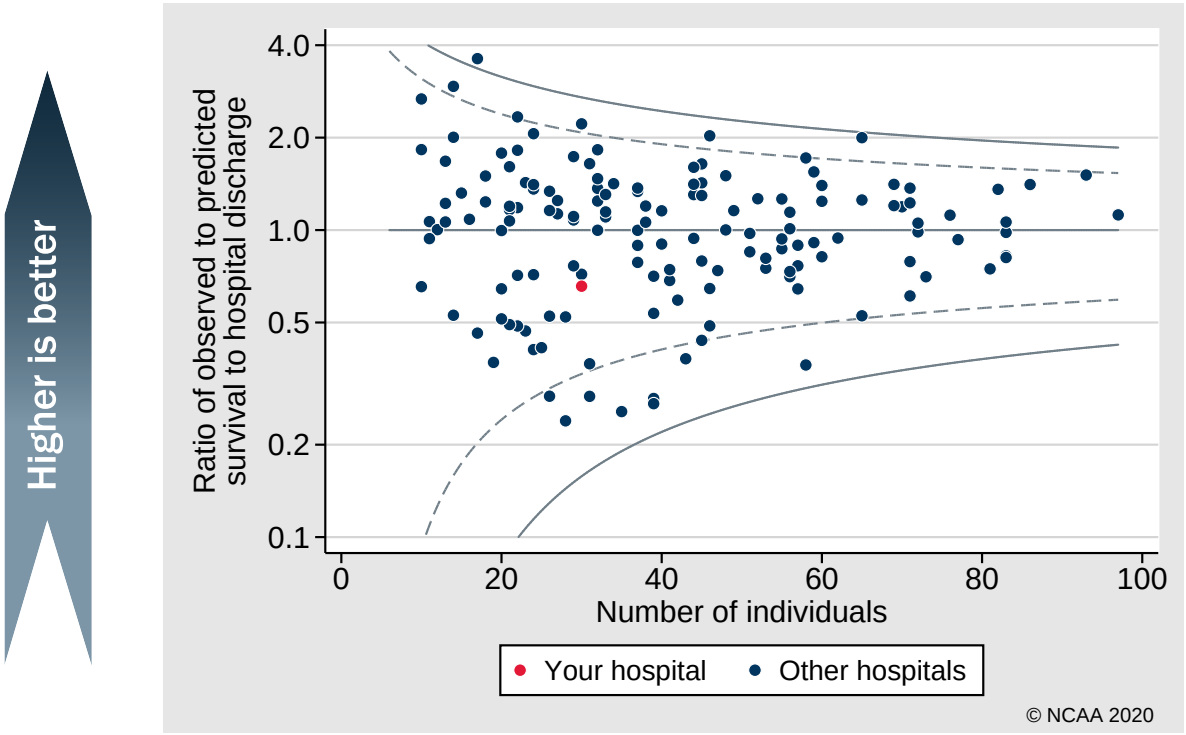
- Read the values for each data point for your hospital (red) as per the steps above and compare this against the data point for NCAA (blue).

Funnel plot of observed to predicted survival to hospital discharge



Your hospital	
Number of individuals	43
Number of observed survivors to hospital discharge	6
Number of predicted survivors to hospital discharge	5.5
Ratio of observed to predicted survival to hospital discharge	1.10
95% confidence interval	(0.52,2.14)

Funnel plot of observed to predicted survival to hospital discharge for arrests on the ward



Your hospital	
Number of individuals for arrests on the ward	30
Number of observed survivors to hospital discharge	2
Number of predicted survivors to hospital discharge	3.0
Ratio of observed to predicted survival to hospital discharge	0.66
95% confidence interval	(0.18,2.10)

Graphical presentation

The plot above shows the ratio of observed to predicted survival to hospital discharge plotted against number of individuals, for your hospital (for the period that this Report covers) and other NCAA hospitals with at least ten eligible individuals (for the most recent twelve months of validated data).

- **Red data point** = ratio of observed to predicted survival to hospital discharge, for **your hospital**
- **Blue data points** = ratio of observed to predicted survival to hospital discharge, for **other NCAA hospitals**

The ratio of observed (i.e. actual) to predicted survival to hospital discharge is presented on the y axis (vertical). It is calculated by dividing the number of individuals that survived to hospital discharge (i.e. observed) by the number of individuals predicted (as calculated by the NCAA risk model) to survive to hospital discharge

Explanations of ratios (y axis (vertical)) in relation to where a data point sits on the plot:

- **Ratio is 1.0** - observed survival to hospital discharge is **equal** to the predicted survival to hospital discharge i.e. the number of individuals that survived to hospital discharge was the same as predicted
- **Ratio is greater than 1.0** - observed survival to hospital discharge is **higher** than the predicted survival to hospital discharge i.e. more individuals survived to hospital discharge than predicted

- **Ratio is less than 1.0** - observed survival to hospital discharge is **lower** than the predicted survival to hospital discharge i.e. less individuals survived to hospital discharge than predicted

The sample size (of the number of individuals) for hospitals is presented on the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point). The level of accuracy is indicated by the funnel lines on the plot.

Standard deviation (SD) funnel lines

Standard deviation (SD) funnel lines on the plot are wider at lower sample sizes (i.e. fewer individuals) given the greater imprecision with small numbers, and narrower at higher sample sizes (i.e. higher number of individuals). Data points for higher sample sizes indicate a more accurate value.

If variation between hospitals is random (i.e. variation of results between hospitals is acceptable) then on average 95% of data points should lie within 2 SD (dashed funnel lines) and 99.8% should lie within 3 SD (solid funnel lines). Where data points lie outside of the funnel lines, this indicates that the variation of the results is **significant**.

Values presented in the table

The exact ratio for the observed to predicted survival to hospital discharge for your hospital is presented in the table. Data points are estimates, therefore 95% confidence interval values are also provided in the table indicating the range of values likely to contain the true value.

Questions

What is the ratio for the observed survival to hospital discharge *to the predicted* survival to hospital discharge *for your hospital?*

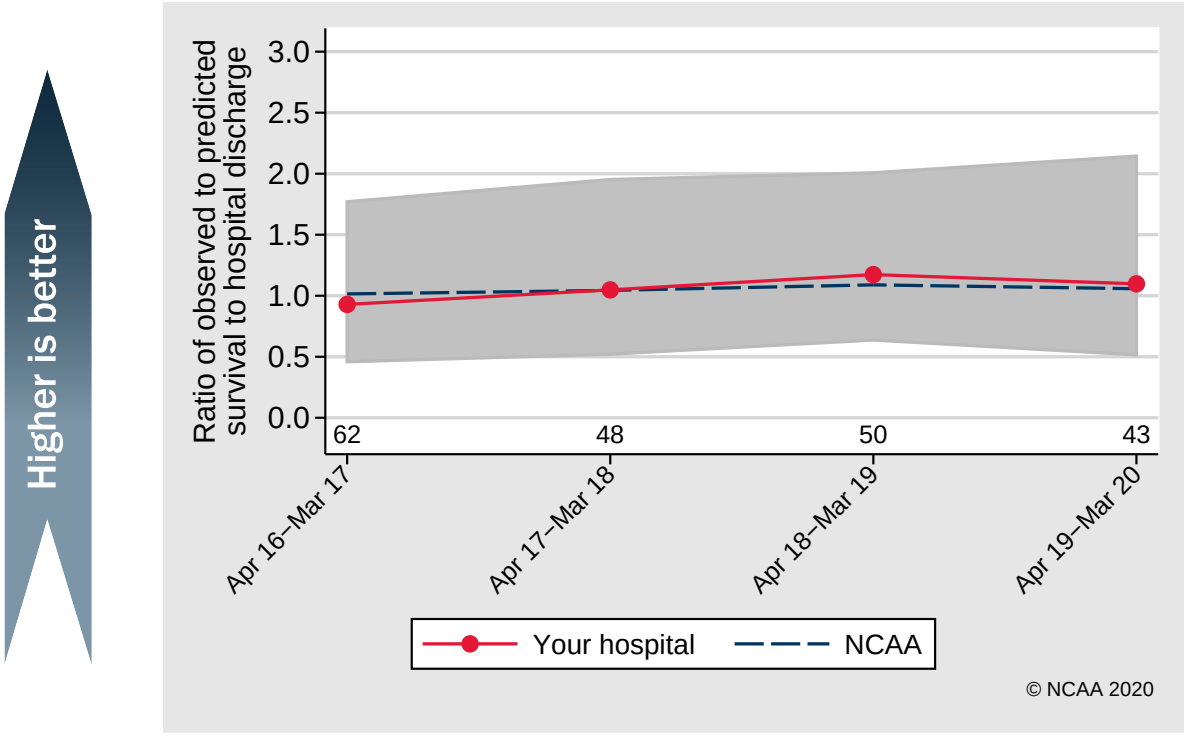
- Read the ratio for your hospital (red data point) on the y axis (vertical).
  Note: the exact ratio for your hospital is specified in the table beneath the graph. Ratios are explained earlier in this section.
- As data points are estimates, the 95% confidence interval values provided in the table, indicate the range of values likely to contain the true value for your hospital.

Where does the red data point for your hospital lie within the funnel, and how does it compare to other NCAA hospitals (blue data points)?

Data point lies:

- **WITHIN** funnel lines - observed survival to hospital discharge is **not significantly different** from predicted.
- **ABOVE** funnel lines - observed survival to hospital discharge is **significantly higher** than predicted.
- **BELOW** funnel lines - observed survival to hospital discharge is **significantly lower** than predicted.

Trend of observed to predicted survival to hospital discharge



Graphical presentation

The graph above shows the trend over time by quarter for the ratio of observed to predicted survival to hospital discharge, at your hospital and NCAA.

- **Red data points and line** = ratio of observed to predicted survival to hospital discharge, for **your hospital**
- **Blue line** = ratio of observed to predicted survival to hospital discharge, for **NCAA**

The ratio of observed (i.e. actual) to predicted survival to hospital discharge is presented on the y axis (vertical). It is calculated by dividing the number of individuals that survived to hospital discharge (i.e. observed) by the number of individuals predicted (as calculated by the NCAA risk model) to survive to hospital discharge.

Explanations of ratios (y axis (vertical)):

- **Ratio is 1.0** - observed survival to hospital discharge is **equal** to the predicted survival to hospital discharge i.e. the number of individuals that survived to hospital discharge was the same as predicted
- **Ratio is greater than 1.0** - observed survival to hospital discharge is **higher** than the predicted survival to hospital discharge i.e. more individuals survived to hospital discharge than predicted
- **Ratio is less than 1.0** - observed survival to hospital discharge is **lower** than the predicted survival to hospital discharge i.e. less individuals survived to hospital discharge than predicted

Periods of data over time (by quarter) are presented on the x axis (horizontal). The sample size for each period for your hospital is presented just above the x axis (horizontal). This can provide an indication of the accuracy of the data point (i.e. a larger sample size can mean a more accurate data point).

The grey shaded area of the graph represents the 95% confidence interval (CI). Each data point plotted for your hospital is an estimate of the true underlying value because it is based on a certain sized sample of data. The true value will most likely lie somewhere within the shaded area.

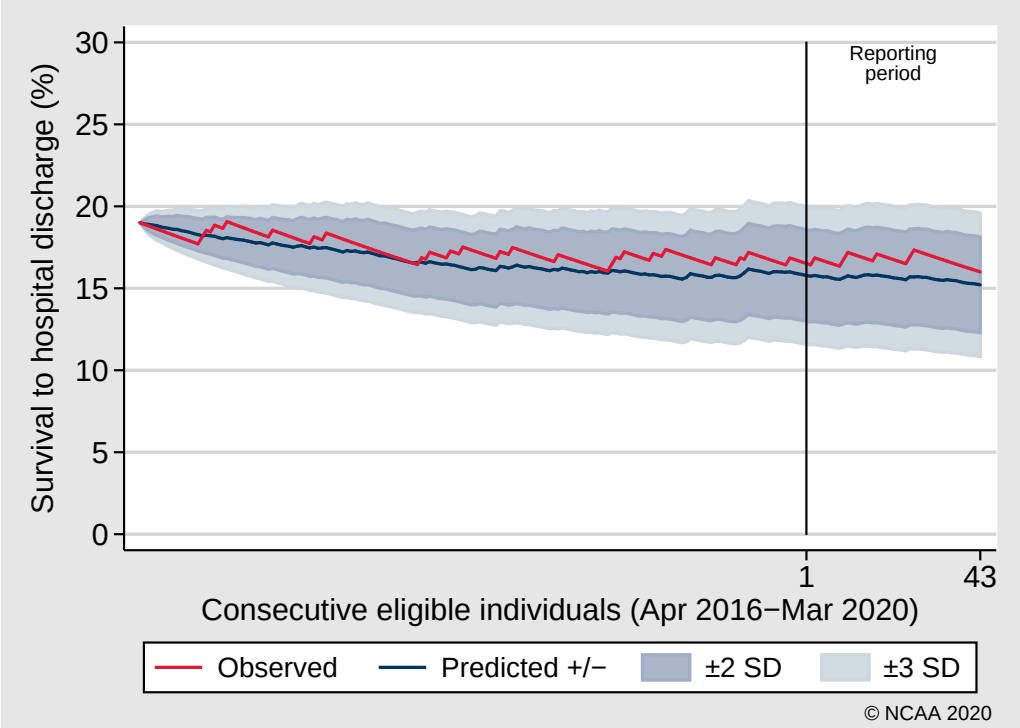
A large sample of data provides a more accurate estimate of the value. Hence, the shaded area will become a narrower. The CI, therefore, gives an indication of how accurately the value has been estimated.

Questions

Is the ratio of the observed (i.e. actual) to the predicted survival to hospital discharge at your hospital greater, less than, or equal to 1.0, over time? Can you see any trend or variation? What could be the reason(s) for this?

- Read the ratio for each red data point for your hospital on the y axis (vertical). Ratios are explained earlier in this section.
- As data points are estimates, the 95% confidence interval values provided in the table, indicate the range of values likely to contain the true value for your hospital.

EWMA plot for survival to hospital discharge



Graphical presentation

The EWMA (exponentially weighted moving average) plot above shows the observed and predicted survival to hospital discharge for consecutive individuals at your hospital, for the period that this Report covers and historically.

- **Red line** = average **observed** (i.e. actual) percentage survival to hospital discharge, for your hospital
- **Blue line** = average **predicted** percentage survival to hospital discharge, for your hospital

Values plotted are averages for the observed percentage survival to hospital discharge at your hospital and predicted (as calculated by the NCAA risk model) percentage survival to hospital discharge for your hospital. Both are presented on the y axis (vertical). The original NCAA risk model is used for individuals prior to April 2018 and the 2018 recalibration for individuals from April 2018 onwards.

Consecutive individuals are shown on the x axis (horizontal). As the sample size increases with each consecutive (additional) individual reported by your hospital, the EWMA sequentially plots the updated values. Consecutive individuals are 'exponentially weighted' - giving a larger weighting in favour of the most recent individuals, smoothing the appearance of the lines.

The vertical black line indicates the start of the period that this Report covers. Values plotted before the vertical black line show historical data for your hospital.

2 SD and 3 SD

The blue shaded areas of the plot (graph) represent 2 and 3 standard deviations (SD) above and below the predicted line (blue).

If variation over time is random then on average 95% of values plotted should lie within 2 SD (dark blue shaded area) and 99.8% should lie within 3 SD (light blue shaded area).

- If the observed survival to hospital discharge line (red) is **ABOVE and outside of the blue shaded areas**, this means that the observed percentage survival to hospital discharge for your hospital is **significantly higher** than the predicted percentage survival to hospital discharge.
  i.e. significantly more individuals survived to hospital discharge than predicted.
- If the observed survival to hospital discharge line (red) is **BELOW and outside of the blue shaded areas**, this means that observed percentage survival to hospital discharge for your hospital is **significantly lower** than the predicted percentage survival to hospital discharge.
  i.e. significantly less individuals survived to hospital discharge than predicted.

Questions

What is the average observed percentage survival to hospital discharge at your hospital, at the end of this reporting period? How does this compare to the predicted percentage survival to hospital discharge at your hospital?

- Read the value plotted at the end of the red line on the y axis (vertical).
- Read the value plotted at the end of the blue line on the y axis (vertical).
- Compare these values.

Are there any variations in the average observed percentage for survival to hospital discharge against the predicted percentage to survival to hospital discharge over time, at your hospital?

- Assess the differences between value plotted for the red line (observed) and the blue line (predicted) across the whole graph (i.e. from where the red and blue lines begin).

The significance of the difference between the value plotted for observed and predicted survival to hospital discharge is indicated by the 2 and 3 standard deviation (SD) shaded areas (see earlier explanation).

Unexpected non-survivors

Hospital non-survivors with a predicted probability of survival to hospital discharge greater than 50%.

Team visit number	Predicted probability of survival to hospital discharge	Date of team visit
No team visits	-	-

Now review suggested questions for local use at the beginning of this section!

10. Quick reference summary of your NCAA Report

Selected analyses/data from the NCAA Report (i.e. same graphs for each hospital) are provided below as key analyses for quick reference.

The period of data covered by this Report is **01 April 2019 to 31 March 2020**.

Further analyses and explanation on interpreting these are provided in the relevant sections within the Report.

Numbers this Report is based on

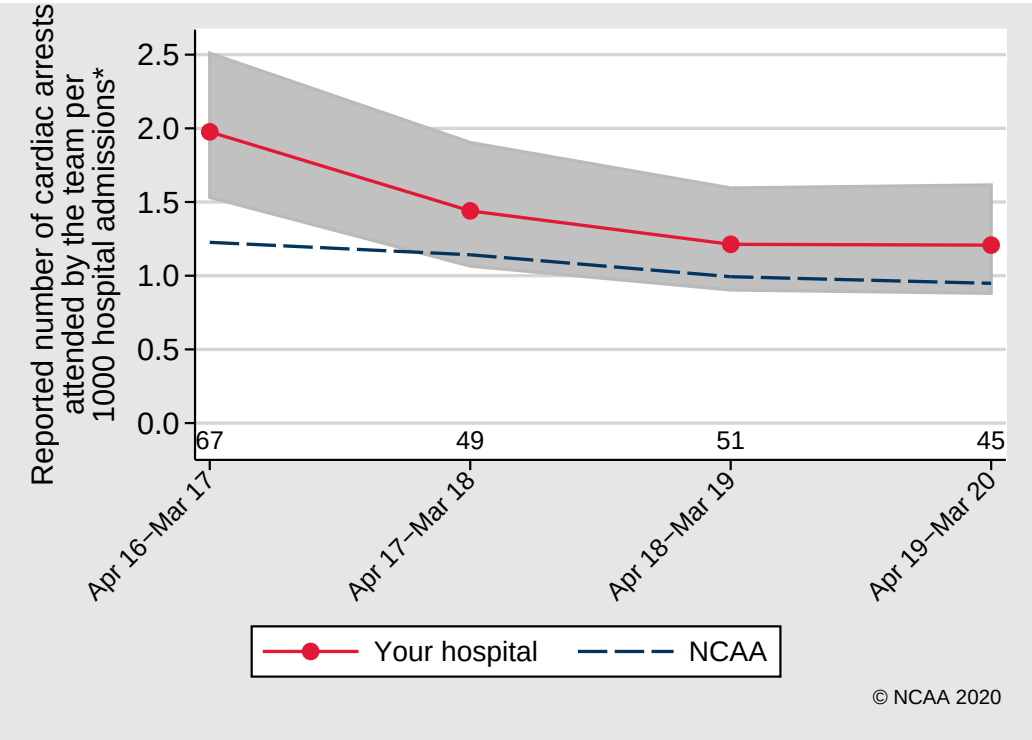
See section 3 'About the data in this Report'.

Period	Total number of admissions to your hospital^	Total number of 2222 calls solely for cardiac arrest	Total number of reported cardiac arrests attended by the team that met the scope of NCAA	Number of individuals
01/04/2019 - 31/03/2020	37,266	46	45	45

Note:
^Total includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)

Rate of cardiac arrests attended by the team per 1000 hospital admissions - trended

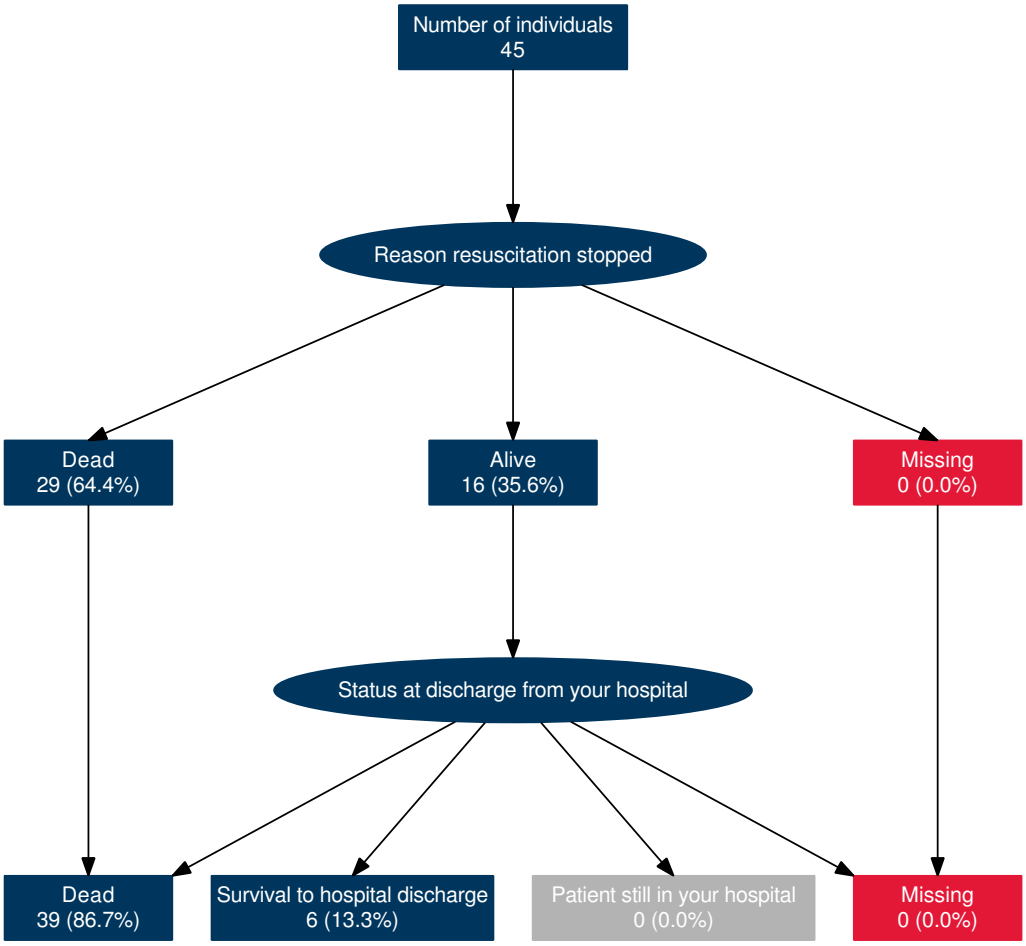
See section 5 'Activity' and heading 'Cardiac arrests attended by the team'.



*Total includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)

Outcome flow

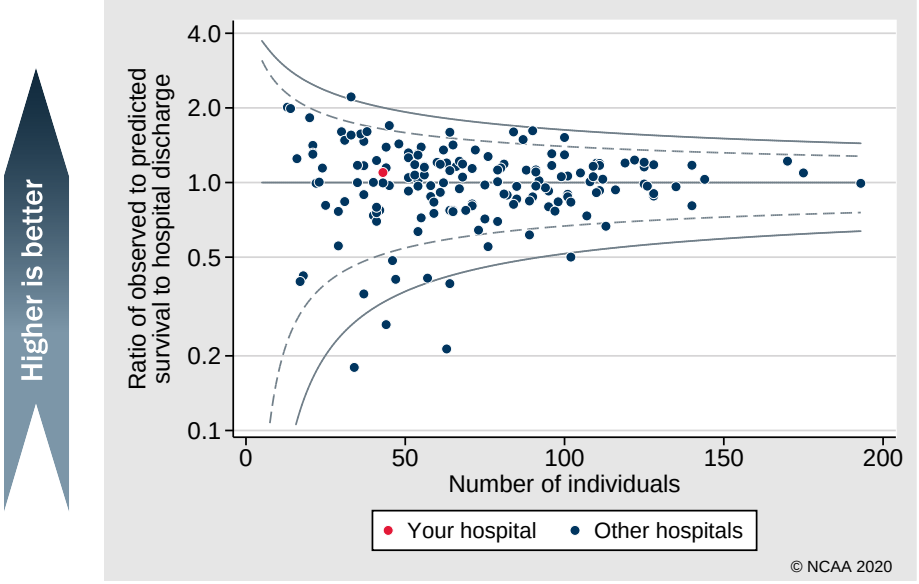
See section 6 'Outcome'.



Note: All percentages shown in this flow are calculated from the overall number of individuals

Funnel plot of observed to predicted survival to hospital discharge

See section 9 'Risk adjusted comparative analyses'.



Your hospital	
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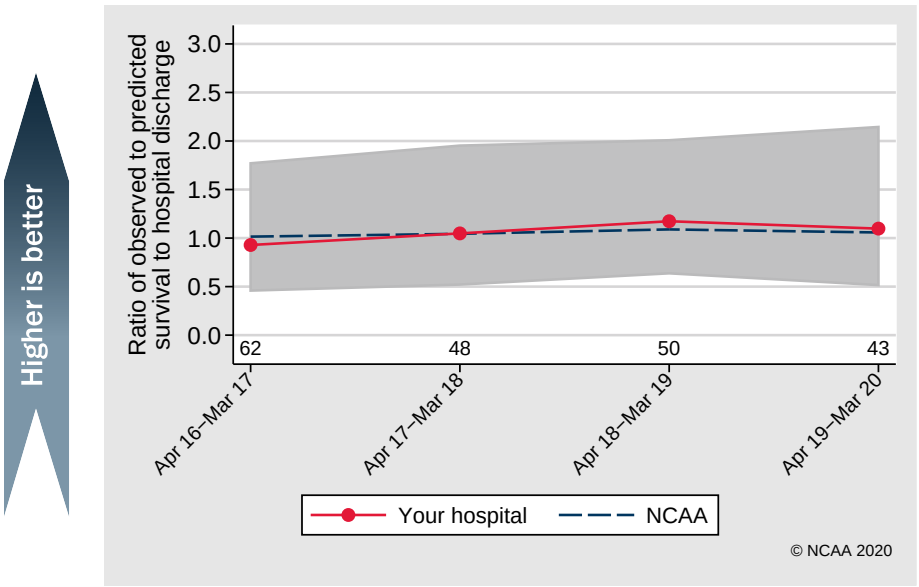
95% confidence interval	(0.52,2.14)

Trend of observed to predicted survival to hospital discharge

See section 9 'Risk adjusted comparative analyses'.



Checklist for using your NCAA Report

As your NCAA Report marks the beginning of your local performance management/quality improvement process, we encourage you to share the information or key points in this Report with relevant staff at your hospital in order to promote wider discussion.

The checklist below suggests some next steps in order to maximise the value of your NCAA Report:

- ☑ **Have you referred back to section 2 'How to use your NCAA Report'?**
- ☑ **Have you shared and discussed results/key points with all relevant staff/teams/ departments/managers at your Hospital, Directors/Boards/groups at your Trust, and any external stakeholders?**
- ☑ **Have you ensured that relevant staff can access this NCAA Report either online (via File Exchange on the secure NCAA online portal) or on a local shared drive?**
- ☑ **Have you made the results of your NCAA Report a standing agenda item at relevant meetings?**
- ☑ **Have you highlighted areas for possible improvement for the next quarter and forthcoming year, and drawn up an action plan of how to achieve this?**
- ☑ **Have you considered feeding your results into local resuscitation training?**
- ☑ **Have you shared local successes in the delivery of care?**

11. Comments on your NCAA Report

If you have any questions or comments about your NCAA Report, then please email the NCAA team (ncaa@icnarc.org).

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 September 2020**
Agenda Item	**TB136/20**	**FOI Exempt**	**No**
Report Title	**Infection Prevention and Control – Annual Report**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Andrew Q Chalmers, Deputy Director of Infection Prevention and Control		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

The purpose of this report is to provide an overall assessment of the previous year's key performance indicators with regards to the IPC programme and evaluate the Trust's compliance against the Health and Social Care act (2008) and the Hygiene Code.

Executive Summary

The report identifies core performance indicators to improve the infection safety for all Trust facilities for the period 2019/20. The 2020/21 work plan is written to focus on infection rates and outbreak management where we have not achieved target or where there are opportunities of stretch. This will be presented quarterly to Quality and Safety Committee for assurance and monitoring.

The definitions for hospital associated Clostridium difficile cases changed in 2019/20 which included a revision of definition of hospital acquired onset time reduction to 48hrs from 72hrs and inclusion of patients who previous were an inpatient in the last 28 days. The trust objective of 16 was exceeded by 16, however 10 cases have been successfully appealed and 6 cases pending appeal. The Trust remains below average compared to other Trusts for this reporting period, however the 2020/21 work plan will focus on further reduction focusing on system wide infection control partnerships as this will have the biggest impact

Performance Highlights to note 2019/20

- Rates of MRSA bacteraemia one – the objective is zero; Trust continues to be a low incidence Trust
- E. coli bacteraemia has reduced by 12% 2019/20
- There is a small increase in MSSA bacteraemia which is slightly above the NW average.
- The Trust continues to be a low risk site for CPE (organism type resistant to some antibiotics)
- Contaminated blood culture results average 7% for the year which is above the expected rate of 3%
- 96% hand hygiene compliance over-all
- Outbreaks of Norovirus particularly were higher than average and expected and informs this years winter plans regarding side-room capacity options
- Hospital environment inspections (HEAT) showed some improvements throughout the year. The ward refurbishment positively influenced some of this, however maintenance programmes are key going forward.

Overall the Trust performance provides assurance, however there is a clear focus in 2020/21 of Route Cause Analysis and learning to inform the IPC programme going forward, estate management, reducing C Diff rates further and outbreak management including management of COVID highlighted in the Board Assurance Framework 2020/21

Southport and Ormskirk Hospital NHS Trust

Recommendations	
The Board is asked to receive the IPC Annual Report and help facilitate the ongoing IPC programme and the actions identified within the report.	
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:**
Andrew Q Chalmers	Bridget Lees

Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk Hospital NHS Trust
Infection Prevention and Control Programme – 2019/20 Annual Report

Executive summary
This report is a review of the annual programme of Infection Prevention & Control service for 2019-20 and reports on the activities undertaken to ensure that the Trust meets the requirements of NHS England and the Care Quality Commission.

The programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- The Revised National Cleaning Standards 2014
- Antimicrobial Stewardship: "Start Smart – Then focus" 2011

The Hygiene Code is underpinned by ten compliance criteria which this year's programme of work is mapped to; this will ensure that the Trust continues to maintain and strengthen its compliance.

Monitoring delivery of the program
Progress against the programme will be monitored by the Infection Prevention and Control Assurance Group.

Abbreviations used in the document

AMD	Associate Medical Director
CBU	Clinical Business Unit
CPE	Carbapenemase Producing Enterobacteriaceae
DIPC	Director of Infection Prevention and Control
DONQ	Director of Nursing and Quality
HAIR	Healthcare-associated infection Review
HCAI	Healthcare-associated Infection
HEAT	Hygienic Environment Action Team
HON	Head of Nursing
IPCAG	Infection Prevention and Control Assurance Group
IPCT	Infection Prevention and Control Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PICC	Peripherally-inserted central catheter
PIR	Patient Infection Review
PLACE	Patient-led Assessment of the Care Environment
RCA	Root Cause Analysis
SIRG	Serious Incident Review Group
SSI	Surgical Site Infection
SONAS	Southport & Ormskirk Nursing Accreditation Scheme

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
1. Systems in place to manage and monitor the prevention and control of infection							
Hold four IPCAG meetings, the minutes of which are submitted to the Quality and Safety Committee with monitored attendance The IPCAG will receive from the IPCT, CBUs and groups reporting to the IPCAG quarterly information on: ○ HCAI performance ○ Audits & surveillance ○ Progress on action plans ○ Outbreaks & Incidents ○ New publication relating to IPC/Microbiology	DIPC	Quarterly	Green	Green	Green	Green	IPCAG meetings were held monthly except for April, September, January and March.
Attendance at and provision of quarterly reports to the Quality and Safety Committee	DIPC	Quarterly	Green	Green	Green	Green	Quarterly reports for 1st and 2nd quarters provided to the Quality and Safety Committee. 3rd quarter report to be submitted to January meeting.
Present the 2019/20 annual programme to the Trust Quality and Safety Committee	DIPC	Annually	Green				The annual report and programme for 2019/20 was submitted and presented to the Quality and Safety Committee
Collate and submit mandatory surveillance data as directed by NHS England onto the data capture system	IPCT	Monthly	Green	Green	Green	Green	Monthly surveillance data submitted by the IPC team and approved by the DIPC. Data also provided to the CCGs and is widely distributed to Trust Managers and Directors
Pharmacy teams to undertake quarterly antimicrobial audits with the support of a Microbiology Consultant and the antimicrobial pharmacist	Antimicrobial Pharmacist	Quarterly	Green	Green	Green	Green	Antimicrobial audits completed quarterly

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Clinical teams within CBUs to lead on the RCA of each case of hospital apportioned *C difficile*, MRSA bacteraemia, device related bacteraemia and gram negative bacteraemia to establish the root cause and identify any lessons learnt	AMDs	Weekly reviews	Amber	Amber	Amber	Amber	The CBUs, Risk & IPC have established a mechanism for presenting and evaluating cases, however there is substantial delay in coordinating chairpersons and arranging clinicians to attend resulting in a back log of cases. This process was updated, however there are still delays and needs further intervention to make sure that the system is more robust and timely.
IPC Team will maintain professional competence by undertaking relevant training and attendance at IPS/HIS Conference for Professional updating	IPCT	Annually	Amber	Amber	Amber	Amber	The IPC nurses have maintained their professional development through the NMC revalidation process. Due to sickness and maintaining the service none of the nurses were able to attend any of the annual conferences and later in the educational events were curtailed due to the COVID pandemic, however there has been a plethora of guidance that has been reviewed and adopted and attendance at teleconferences
2. Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections							
Facilitation of internal HEAT Inspection process within clinical settings with reports to the IPCAG	IPCT	Monthly	Green	Green	Green	Amber	The IPC team has facilitated inspections throughout the year however in quarter 4 very limited inspections took place due to the COVID pandemic, however during this time the IPC nurses and Trust senior nurses were making regular daily visits to all the wards to provide assistance and guidance and support
IPC Team support and attendance at Water Safety Committee	IPCT	Quarterly	Green	Green	Green	Green	The IPC Consultant nurse and/or Infection Control Doctor (acting Infection Control Doctor) have been in attendance at these meetings and provided expert advice and have assisted in water audits
IPC Team support and attend the Decontamination Committee	IPCT	Bi-monthly	Green	Green	Green	Green	The IPC Consultant nurse and/or Infection Control Doctor (acting Infection Control Doctor) have been in attendance at these meetings and provided expert advice

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Provide expert advice to all service developments to ensure infection risks are considered, in particular in the built environment from planning stage to commissioning	IPCT	Ad hoc	Green	Green	Green	Green	The IPC team have been involved in numerous building projects including: ward refurbishments, AED CDU, Therapy pool shutdown and annual maintenance, theatre shutdowns and maintenance, COVID screening Pod makeover, NWRSIC refurbishment
Review of cleaning products and practices in line with national guidelines and scientific evidence	IPCT	Ad hoc	Green	Green	Green	Green	Disinfection wipes disinfectants, UVC light disinfection, hydrogen peroxide vapour and cleaning schedules have all been reviewed to ensure the best outcomes. In addition single use antimicrobial recyclable curtains have successfully been introduced and air mattresses are now part of a managed service.
3. Provide suitable accurate information on infections to the patient, public and other service providers							
Work with PALs, Complaints, Risk and Communication teams to provide timely and accurate information to press enquiries, FOI requests, patient concerns and complaints	IPCT	As required	Green	Green	Green	Green	The IPC team provides information and assists with complaints and FOI requests, and works with PR and Coms with respect to press releases as required
Patient information leaflets to be available on the Trust website	Comms Team IPCT	As required	Green	Green	Green	Green	Patient leaflets available on MRSA, C diff, Norovirus and Influenza. Information on IPC practices and hand hygiene also available in patient admission booklets. Also utilise NHS and PHE leaflets on CPE, VRE and food borne illnesses. During the coronavirus pandemic information leaflets have been provided to patients and those requiring screening.
Provide IPC data to CBUs for local information boards for clinical areas	IPCT	Monthly	Green	Green	Green	Green	Monthly IPC Performance report distributed acr the Trust

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion							
Continue inserting information stickers for C diff in the health records of patients and provide relevant patient information leaflets	IPCT	As required	Green	Green	Green	Green	Every in-patient who has a community or hospital acquired C diff infection is noted in the patient's notes and an information leaflet is provided to each affected patient
Flagging on patient administration system (Medway) of C diff, MRSA, CPE, VRE or other significant organisms that have an infection risk for appropriate management on readmissions	IPCT	As required	Green	Green	Green	Green	Every patient who is colonised or infected with MRSA, C diff, CPE, VRE or other significant multidrug resistant organism is alerted on Medway so that clinicians are alerted on subsequent admissions so that the appropriate precautions can be taken
Raise awareness on current IPC issues within the Trust; - Monthly Performance Reports - Mandatory Training to include current issues - Themed articles to be published in Trust News - Table top training and ward visits - Ad-hoc drop-in training sessions as required when new situations arise	IPCT	Monthly As required	Green	Green	Green	Green	The IPC team identifies issues and learning points from monitoring, surveillance, inspections, RCAs, PIRs, incidents and outbreaks and incorporates these into the monthly performance report and into mandatory training. Articles are also included in Trust News and are part of the table top training exercises provided on both sites. During the Coronavirus pandemic in addition to the IPC team nurses who were redeployed visited wards on a daily basis to provide training on donning and doffing and also on respirator use.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to others							
Results of correct isolation on admission (MRSA) and isolation of diarrhoea until after specimen result is known, published in monthly performance report	IPCT	Monthly	Green	Green	Green	Green	Information provided to CBUs in each monthly performance report
All patients screened positive for MRSA and previously known to be MRSA positive to be prescribed suppression therapy. IPCT audit compliance with MRSA Pathway	IPCT	Monthly	Green	Green	Green	Green	The IPC team provides a monthly report to CBUs on compliance to the MRSA pathway
Action plans for results of MRSA Pathway Audits presented at IPCAG	HON	Quarterly	Amber	Amber	Amber	Amber	CBU reports are often limited and therefore provide only limited assurance of actions undertaken and improvement
IPC Team to facilitate comprehensive surveillance system for HCAI with monthly reporting (Appendix 1)	IPCT	Monthly	Green	Green	Green	Green	The IPC team facilitates HCAI surveillance as identified in appendix one
Maintain close links with relevant agencies (Public Health England, NHSE, NHSI, CCGs and providers of Community IPC Services) to ensure that robust communication channels are maintained	IPCT	As required	Green	Green	Green	Green	The IPC team maintains close links with local agencies with frequent communications through telephone, e-mails and meetings

6. Ensure all staff are fully involved in the process of preventing and controlling infection							
A requirement to comply with infection prevention and control is included in all job descriptions: Zero tolerance to non-compliance with IPC practices to be monitored and following procedure introduced; 1st observation -	Human Resources Matrons	As required	Green	Green	Green	Green	The IPC nurses have identified issues regarding hand hygiene, PPE and cleaning, however it has been our experience that staff have been responsive to reminders and instructions and haven't needed to be escalated.

File note and discussion with line manager 2nd observation - Interview with higher manager/director 3rd observation - Disciplinary process commenced	Consultants EMD DON IPCT						
Clinical and Nursing staff attend RCA meetings to ensure robust process	Matrons AMDs	As required	Amber	Amber	Amber	Amber	Doctors and/or nursing staff are not always in attendance at RCAs which have been organised by the CBUs – this delays the process and interrupts the learning processes that may otherwise be disseminated
Local and personal IPC Performance is discussed at staff appraisal	All Managers	As required	Green	Green	Green	Green	IPC is part of staff appraisals who work in a clinical setting
7. Provide or secure adequate isolation facilities							
IPCT and Bed Managers maintain the isolation information spreadsheet on the Trust Intranet to ensure that availability of isolation facilities is apparent	IPCT Clinical Coordinators	Daily	Green	Green	Green	Green	The isolation room spreadsheet is updated by the IPC team each morning from the Clinical Coordinators night time update and is updated throughout the day by the IPCT in response to patient and laboratory updates and then a final review in the afternoon with each ward being contacted. The IPC nurse on-call will also update the spreadsheet on a weekend with any relevant changes identified while working through laboratory results. As an adjunct to the Trust's side rooms during the Coronavirus pandemic 8 pop-up isolation rooms were purchased to further enhance patient safety – these are mobile units that can be used around the Trust as the need arises.

IPCT provide advice and support on the management of infectious patients during an increased incidence of infection or outbreak to contribute to management of appropriate usage of the side rooms	IPCT	As required	Green	Green	Green	Green	The IPC team continually is gathering syndromic and laboratory intelligence with respect to potential incidences and outbreaks and initiates investigations and incidence and outbreak meetings as required. 1st quarter: 10 outbreaks of Norovirus, numerous sources including admissions, visitors and relatives, possible transference in AED or even ambulance environments, nursing/care homes, confused patients walking around the wards in some cases trying to be helpful – the occurrences in the hospital mirrored incidences in the community especially when mapped to NWRSIU leading to replacement of lost domestic hours, increased cleaning and disinfection of patient areas using UVC light disinfection and repair of environmental temperature control. Nursing/care homes. At the end of the quarter identified a patient with an antibiotic resistant Klebsiella infection, further review went onto identify a number of colonised patients; because of this the centre became closed to admissions and a process of refurbishment and deep cleaning occurred especially since environmental swabs were returned as being positive. 2nd quarter: the work on the NWRSIC continued with repeat fortnightly screens and improved environmental hygiene – this process was successful at reducing the number of new colonisations to eventually zero. 3rd quarter: 3 wards with bays affected by influenza type A and 1 ward with norovirus. During these outbreaks applied the influenza, isolation and gastroenteritis IPC policies to good effect and was able to contain and control.

Patients identified with Type 5-7 stools (as defined by the Bristol stool Chart) are isolated within 2 hours	Nurse in charge of Ward Clinical Coordinators	As required	Amber	Red	Amber	Amber	Reported on the monthly performance report 1st quarter averaged 43% 2nd quarter averaged 17% 3rd quarter averaged 53% 4th quarter averaged 67% Rapid isolation as evidenced above is problematic mostly due to the availability of side rooms, but also due to the high bed occupancy making it difficult to move patients as needed. The Trust continues to pursue greater efficiency in managing patient flow in working with partner organisations, red to green initiatives and board rounds.
8. Secure adequate access to laboratory support as appropriate							
Laboratory standard operating policies and procedures meet Clinical Pathology Accreditation standards	Lab Manager Contract Monitor	As required	Green	Green	Green	Green	The laboratory has been inspected and meets the required standards
Issues with respect to provision of laboratory service to be monitored by the Trust Contract Monitor so as to ensure the provision of an adequate level of service that will ensure that Trust IPC needs are met	DIPC IPCT Contract Monitor	As required	Green	Green	Green	Green	The laboratory contract is monitored by the Trust Contract Monitor and the IPC Consultant Nurse maintains close contact with the laboratory managers
9. Have and adhere to policies and protocols for the prevention and control of HCAI							
IPC policies include the IPC Policy, Isolation Policy, Management of Gastroenteritis, Influenza Policy, and Hand Hygiene Policy, there is also a recent Coronavirus policy and these are backed up by the Infection Prevention and Control Manual which provides guidance on all other aspects of Infection prevention and Control	IPCT	As required	Green	Green	Green	Green	The monitoring of these policies is through IPC audits which are reported in the monthly IPC performance reports

Compliance with the Hand Hygiene Policy is audited each month and results are published in the monthly performance reports	Link Workers IPCT	Monthly	Green	Green	Green	Green	1st quarter average 92% 2nd quarter average 94% 3rd quarter average 98% 4th quarter average 96% The number of audits conducted by IPC link workers was reduced in March due to the restrictions going between wards during the Coronavirus pandemic
IPCT Annual Audit Programme (Appendix 2)	IPC Team	Monthly	Green	Green	Green	Green	The IPCT audits are completed monthly and reported on the IPC Monthly Performance report
10. Ensure so far as is reasonably practicable that healthcare workers are free of and are protected from exposure to infections during the course of their work, and that all staff are suitably educated in the prevention and control of infection							
All staff must attend IPC training at induction; following induction clinical staff and non-clinical staff who work in a clinical environment are required to have annual updates. Attendance is monitored at the CBU and Trust Quality and Safety meetings	Assistant Directors of Operations	Yearly	Amber	Amber	Amber	Amber	The IPC Consultant Nurse and Matron provide IPC training for all staff as part of induction as well as providing annual mandatory training for all staff working in a clinical area – these are typically arranged by Education & Training, but in addition to this Womens and Childrens services, Consultants and Theatres are provided their own training – this is also offered to AED. Training is also provided to Student Nurses, ACORNS and medical students. Compliance across the organisation for IPC mandatory training averages 75%. In the last quarter due to the effects of Coronavirus and social distancing IPC training became web based
Update mandatory IPC training for clinical and non-clinical staff as per Trust training needs analysis to include; - Feedback on performance - Incidents including RCAs - Audit results	IPCT	Monthly	Green	Green	Green	Green	Mandatory IPC training includes updates on KPIs and learning points from RCAs and incidences

To continue with the link worker educational programme; - Quarterly meetings. - IPCN to provide educational sessions to support link workers in their role. - Managers to allocate dedicated time for link workers to attend meetings and complete Hand Hygiene audits	IPCT Ward Managers	Quarterly	Amber	Amber	Amber	Amber	IPCT provides the training sessions, however only a limited number of areas are represented. The above is true of each quarter – the IPC team continue to invite link workers from their respective areas and copy in the ward managers and matrons to arrange for their staff attendance
Provide ad-hoc training as required/need identified	IPCT	As required	Green	Green	Green	Green	Ad-hoc training provided for ANTT, respirator fit-test train-the-trainer, cannula safety, influenza precautions, norovirus precautions, commode and other equipment cleaning,
Staff Health and Wellbeing are standing members of the IPCAG and report employee incidences as related to IPC and review policies and guidance	IPCT Staff Health and Wellbeing	Quarterly	Green	Green	Green	Green	A representative from Staff Health and Wellbeing attends IPCAG meetings as scheduled
In collaboration with Procurement review equipment and consumables to ensure that purchases are cost-effective and meet IPC requirements	IPCT Procurement	As required	Green	Green	Green	Green	A representative from the IPCT attends the procurement meetings and has made recommendations on clinical equipment and products

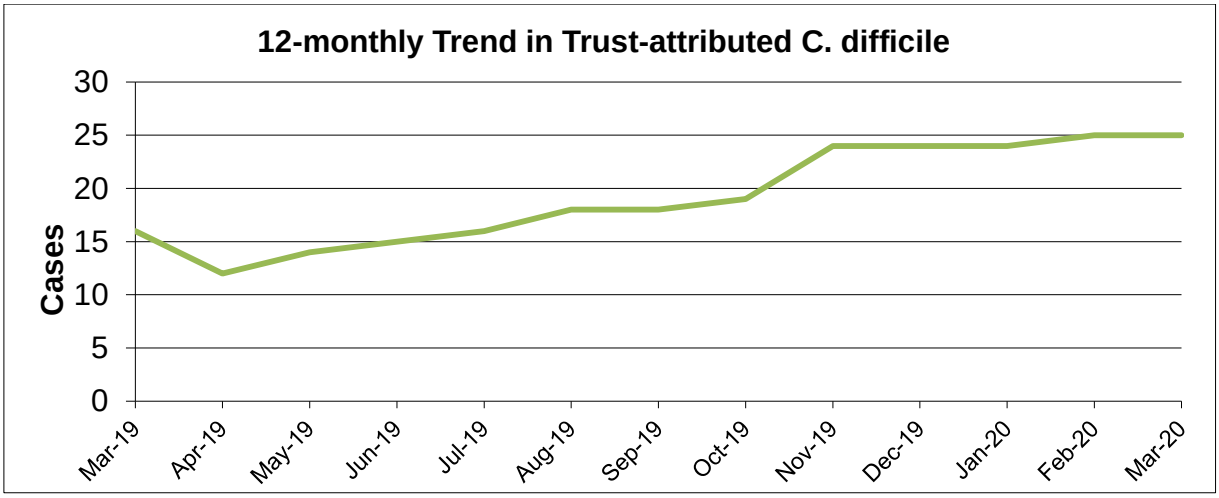
IPC KPIs and Related Actions

C. difficile Infections (CDI)

The 2019-20 C diff objective as given by NHS Improvement for Southport & Ormskirk Hospital NHS Trust to have no more than 16 infections, however the criteria for case assignment changed from the previous year. The changes included:

- Hospital attribution decreased from 3 days to 2 days post admission e.g. patients who were symptomatic and tested positive after 2 days were now hospital acquired whereas before it was after 3 days
- Hospital attribution also now included cases that occur in the community (or within 2 days of admission) when the patient had been an inpatient in the trust reporting the case in the previous four weeks

Given the above changes there was an expectation that C diff attributed to hospitals would increase which in part is evidenced by the chart below which compares the total number of C. diff cases for a given 12 month period, hence from March 2019 the Trust trend has slowly been increasing; a similar trend has been evidenced by neighbouring trusts (see chart at the end of this review). Importantly the trust remains below average compared to other trusts. In addition Trusts can appeal cases where there are no lapses in care identified which is referenced further in this text as is importantly learning from cases.

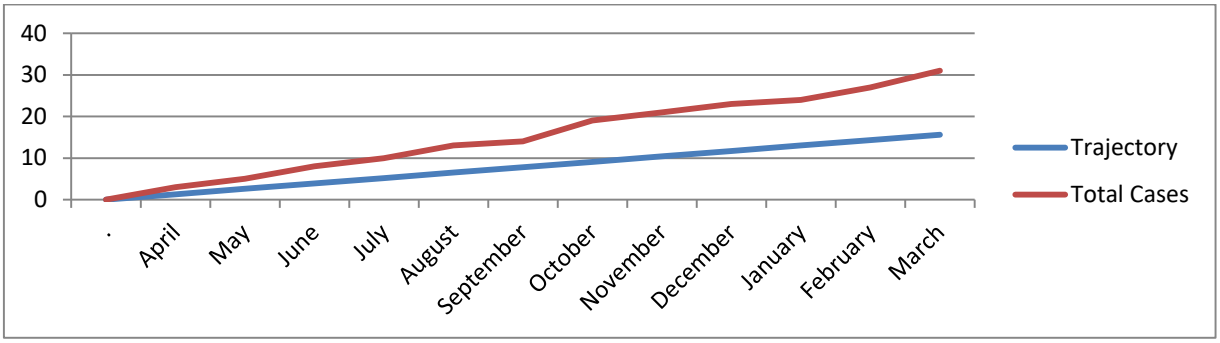


C. diff. cases against trajectory 2019/20

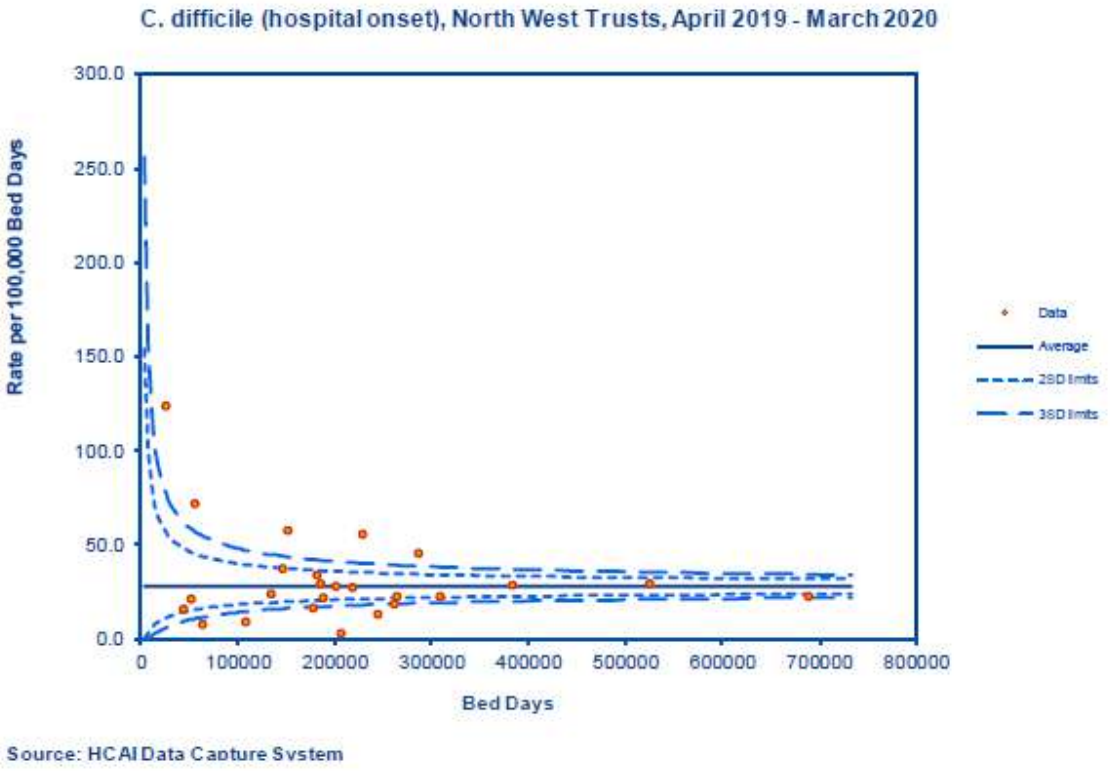
The chart below shows the blue line as the yearly objective of 16 cases divided over 12 months; the actual cumulative totals are shown in red and exceeds the target, however 10 cases have been successfully appealed and a further 6 cases will be presented to the CCG for appeal as no lapses in care have been identified.

The lapses in care typically fall into two causes:

1. Inappropriate antibiotic prescribing – these range from extended duration, to not obtaining microbiological evidence for prescribing choices, to poor antibiotic choice,
2. Not isolating the patient urgently who has symptoms of diarrhoea.



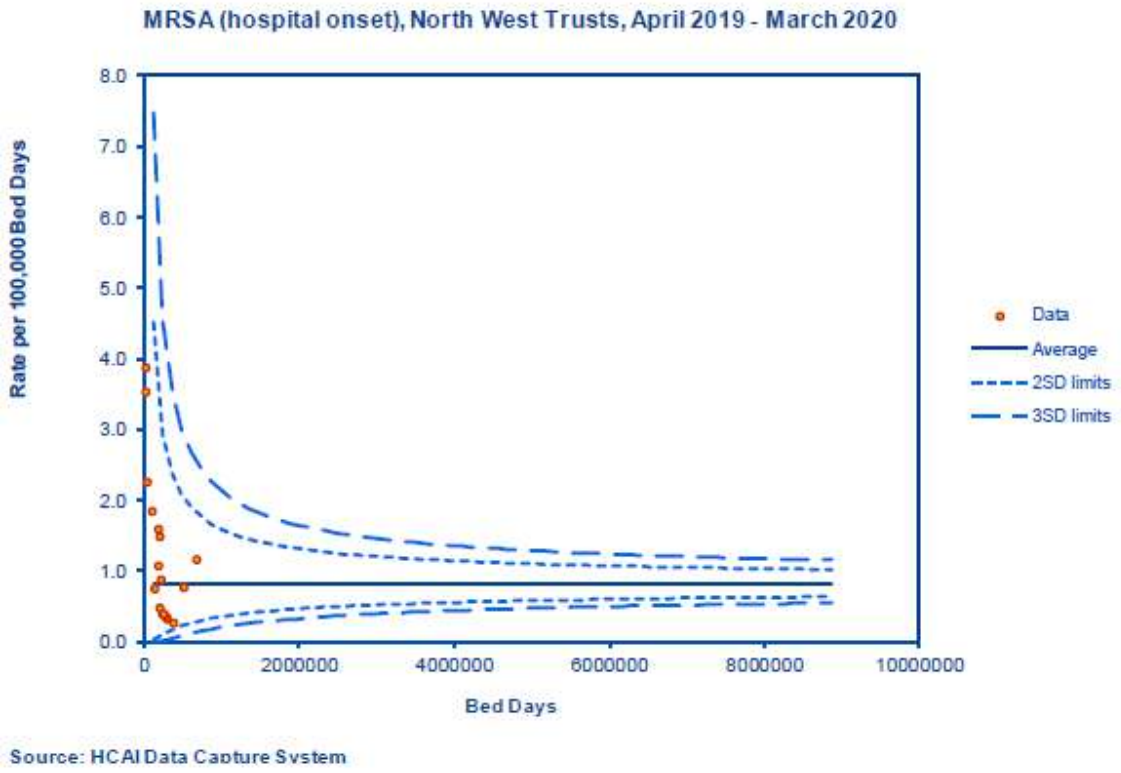
The 2019-20 Trust rate for C diff infection is 23.8, hence in reviewing the chart below for Northwest (NW) hospitals Southport & Ormskirk are just below the NW average.



Action: IPCT to continue to monitor, provide education and respond to C diff cases to ensure the safety of affected patients and the safety of others. In addition an antimicrobial app has been procured by the Trust and the adult antimicrobial guidelines have been updated and will soon be available on PCs, smart phones and I pads – the new formulary decreases the amount of Cephalosporin antibiotics which carries a greater risk of C diff infection occurring, also to consider preventive treatment used at nearby hospitals for at risk patients. **Due: 1st September 2020**

MRSA Bacteraemia & MRSA Screening

The last Trust acquired MRSA bacteraemia was in August 2019 – the target for MRSA bacteraemia is zero. The annual rate for Southport & Ormskirk is 0.7, in reviewing the chart below the Trust is below the NW average and remains a low incidence trust.



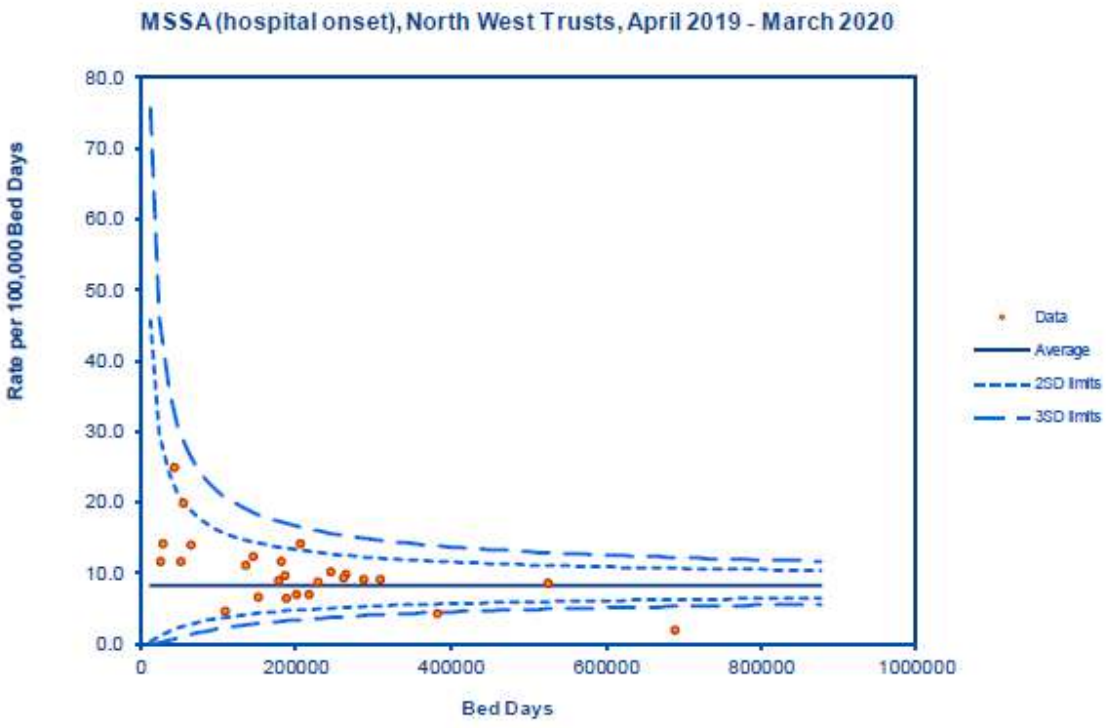
Source: HCAI Data Capture System

The average MRSA screening compliance for the Trust was 95%. Breaking this down elective screening averaged 99% and emergency was 93%.

> **Action:** IPCT to feed back to CBUs missing MRSA screens and record on Datix. Where possible the team will also identify patients whose screens have been missed and if they are still in-patients request the in-patient area to complete the screen. The IPC team to continue to review MRSA pathways and report to ward staff if positive patients not prescribed suppression treatment. For any new MRSA positive patients the IPCT will not only inform the nurse in charge and place an alert on Medway, but will also place an alert in the patient's case notes. **Due: MRSA screening to be reported monthly to CBU, new MRSA stickers already introduce in May 2020.**

MSSA Bacteraemia

The Trust had 13 MSSA bacteraemia for this time period with a rate of 11.1. The chart below shows the Trust is just above the NW average, but within the 2 standard deviation limit.



Source: HCAI Data Capture System

E coli Bacteraemia

There were 23 hospitals acquired E coli bacteraemia in this time period which is a decrease of 3 cases from last year; the rate is 17.8 which places the Trust below the NW average. What makes this more remarkable is the Southport & Formby CCG rate is the highest in the North West.

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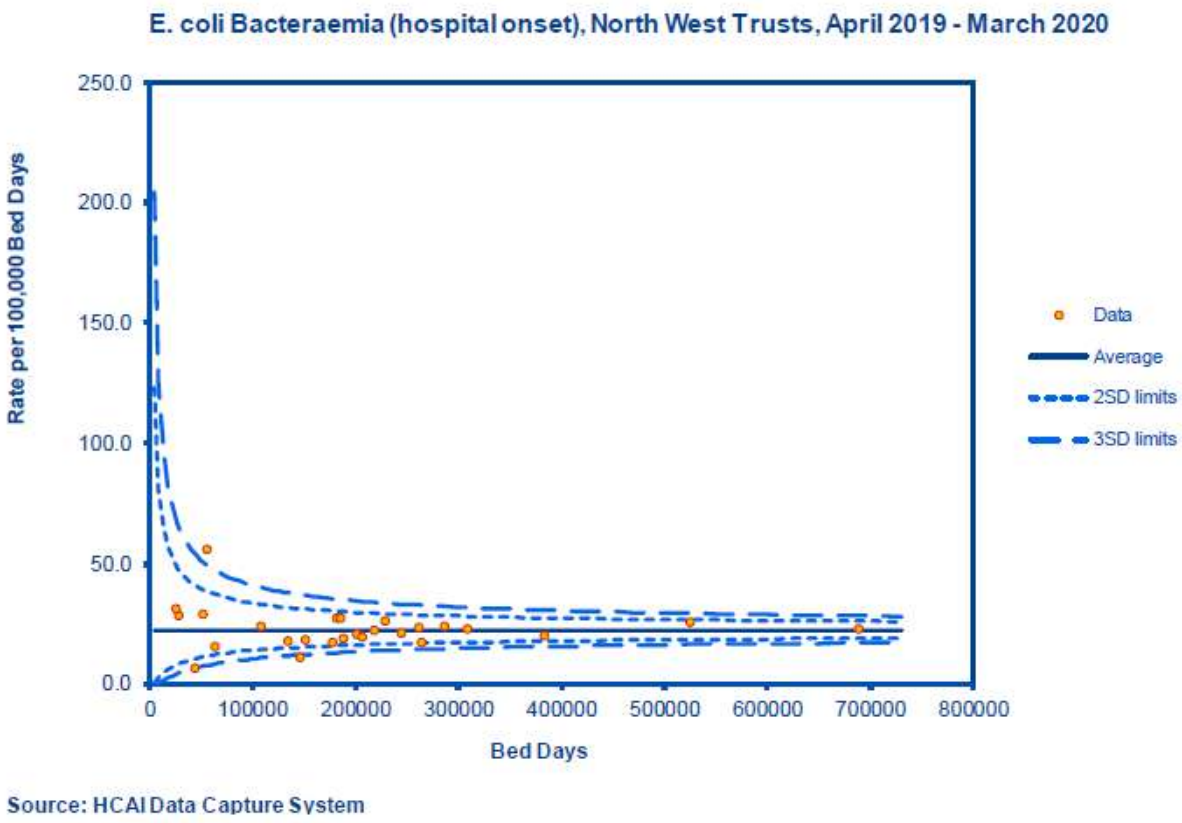
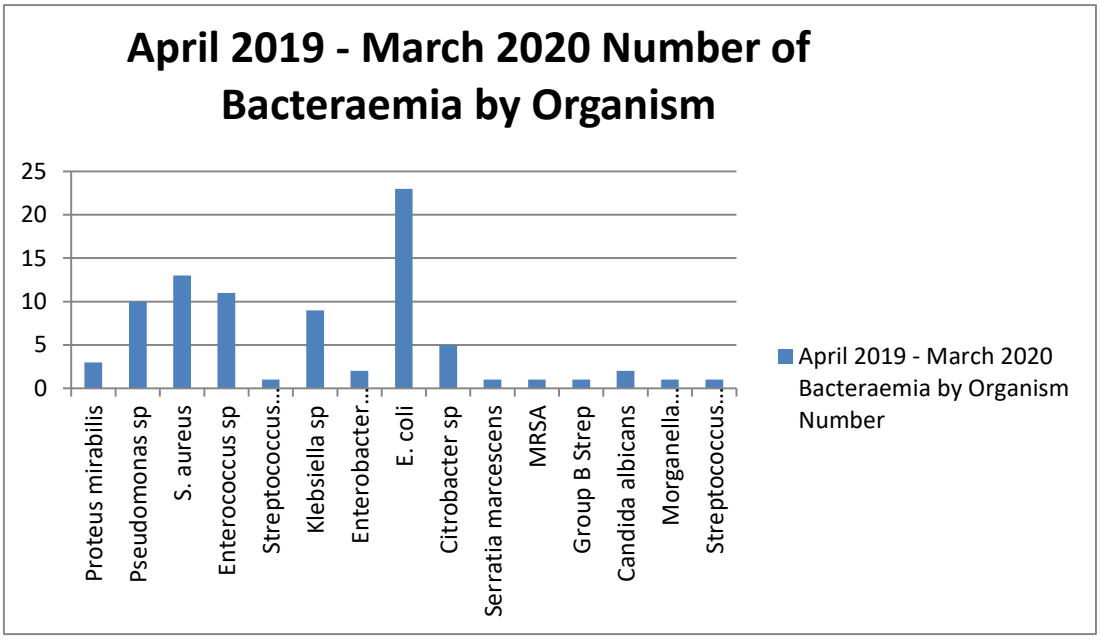
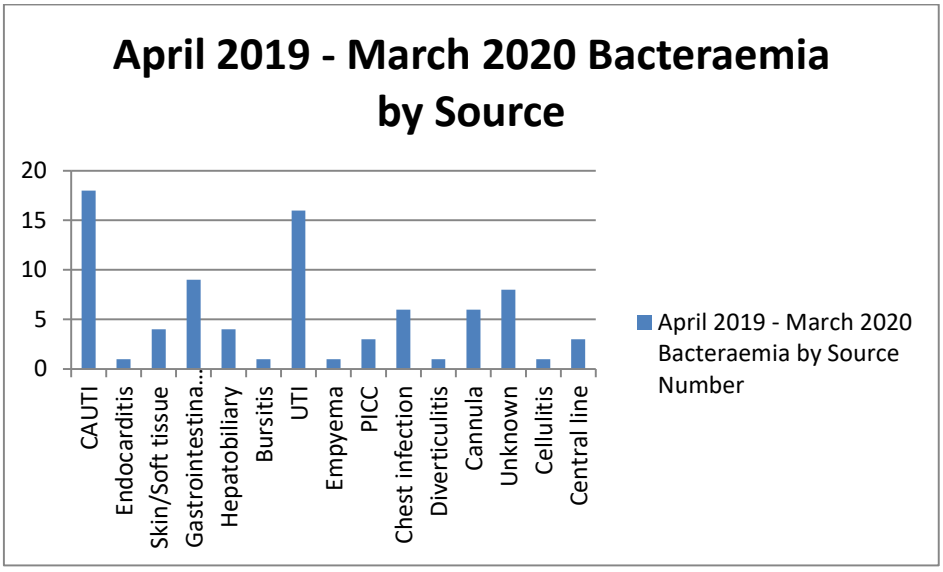


The chart below shows that E coli is by far the most common organism to cause bacteraemia.



The next chart shows the most likely source of bacteraemia infection. Perhaps unsurprisingly this is catheter associated urinary tract infection (CAUTI) and non-device UTI. This is important in targeting actions to reduce these types of infection.

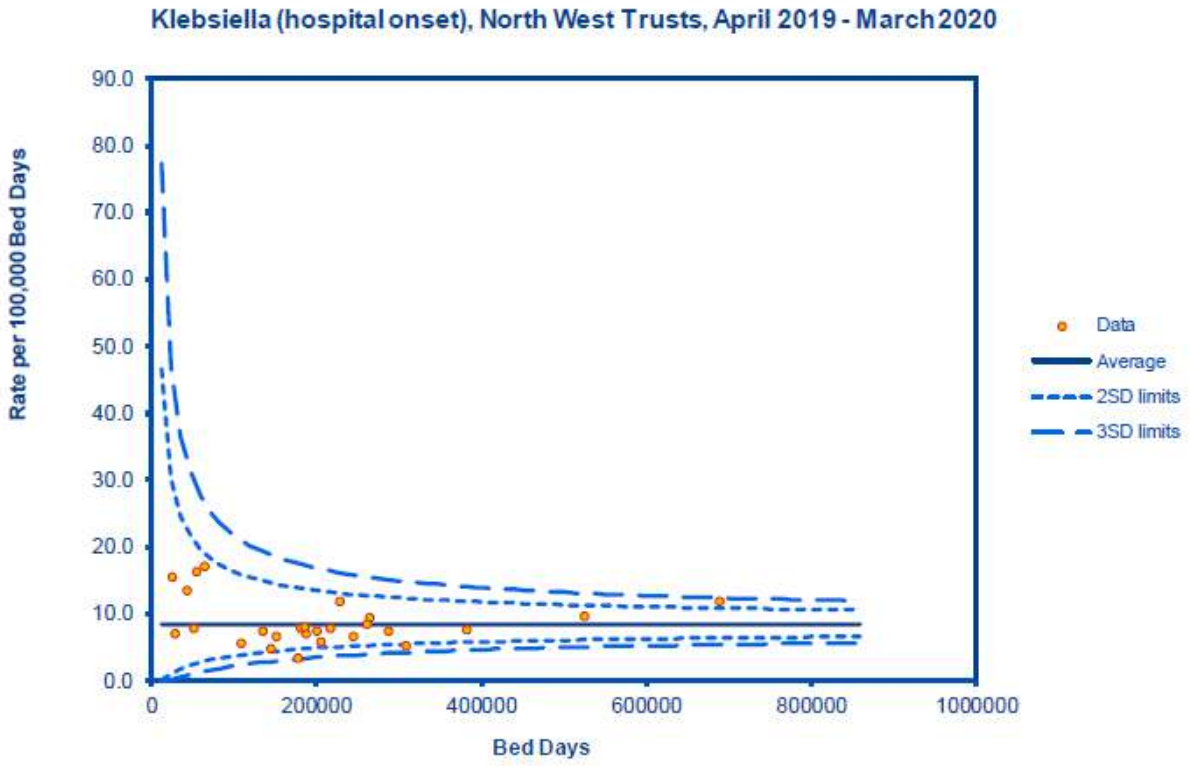


The IPC team continues to provide education and training in preventing urinary tract infection and monitors the use of catheters and catheter care plans giving feedback to clinical areas.
The team is also part of the North Mersey Gram Negative Blood Stream Infection reduction group and the Cumbria and Lancashire HCAI Collaborative led by NHSE/I to share knowledge and actions in reducing these infections across the health economies – though during this last quarter meetings haven't take place due to the Coronavirus pandemic.
Prior to COVID a team consisting of the Urgent Care Matron, IPC Consultant Nurse, Antimicrobial Pharmacist and Consultant Microbiologist.began auditing and instructing 3 wards in the principles of HOUDINI which is an acronym for indications for a catheter – all other reasons the catheter should be removed, or not placed in the first place.
The team alerts the CBU of these infections and assists the CBUs in the RCA process.

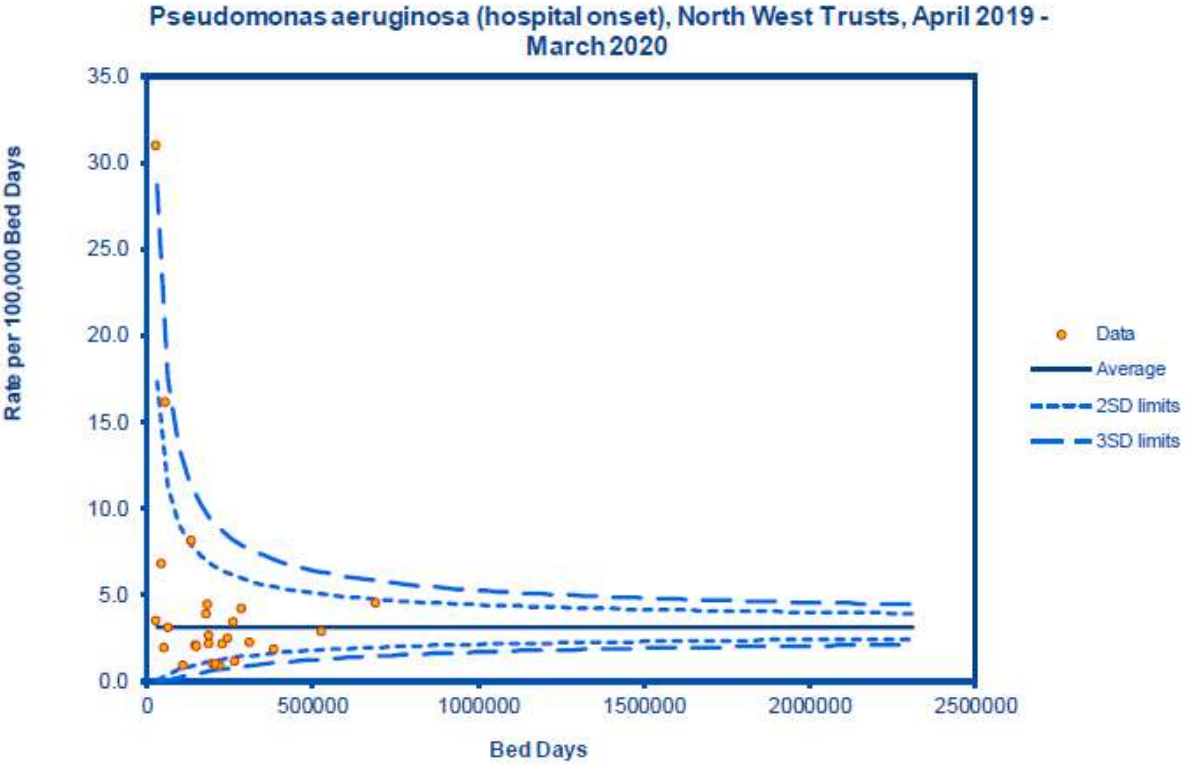
> **Action:** IPCT to continue to monitor and provide education and engage with health economy colleagues; CBUs to arrange and conduct RCA meetings. Work with the Matrons to implement HOUDINI protocols **due: provide monthly training and provide feedback through monthly reporting and by expand the HOUDINI process across the Trust by 1 September 2020.**

Pseudomonas and Klebsiella Bacteraemia

The charts below show the rates of bacteraemia for both pseudomonas (rate 8.2) and Klebsiella (rate 7.4) occurring in 2019-20, Klebsiella is below the NW average, but pseudomonas is above the NW average at 2 standard deviations, however Southport & Formby CCG has the highest community rate in the NW at 3 standard deviations above the average.



Source: HCAI Data Capture System



Source: HCAI Data Capture System

He reviewing the sources of infection for these organisms many were due to UTI and CAUTI therefore the projected work for E coli bacteraemia will also help to reduce the incident of these infections.

Action: Chest infection, UTI and catheter associated UTI are additional areas of focus for mandatory training and ad-hoc training as provided by the IPCT. In addition to training, audits have been completed on UTI and treatment on the Emergency Assessment Unit and catheter care plan audit on the Short Stay Unit; these audits are ongoing and reported in the IPC monthly performance report. The Trust is also supporting nutrition and hydration initiatives and the introduction of the introduction of the ANTT® E-learning training will also provide the clinical education and awareness with respect to managing clinical devices. **Due: provide monthly training and provide feedback through monthly reporting.**

CPE Screening

During this year 965 CPE admission screens were obtained from patients who were identified as being at increased risk of CPE colonisation, 9 were found to be positive, however most of these patients were already known to be CPE positive with the remainder having been transferred from the Royal Liverpool University Hospital (1), the Walton Centre (1) and from a Greek hospital (1).

The overall low number of CPE cases all of which were not due to transmission within the Trust continues to identify the Trust as a low risk hospital for CPE.

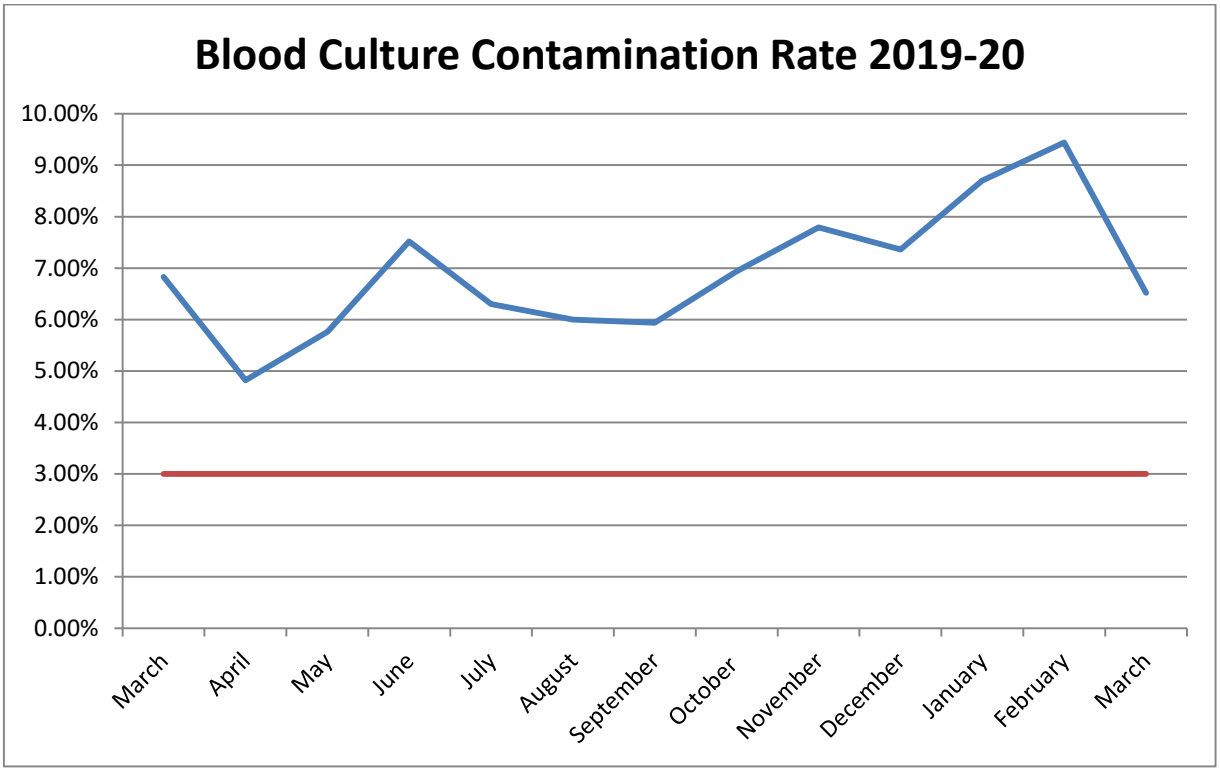
Action: Continue to monitor for CPE colonisation and follow the PHE guidance. Consider screening amendments based on changing patterns. Work with partner organisations to identify potential cases and screen contacts. **Due: provide monthly training, provide feedback through monthly reporting and attend quarterly meetings with partners.**

Blood Culture Contamination

The chart below shows the blood culture contamination rate in 2019-20.

The red line shows what should be achievable, however the Trust's contamination rate is consistently above this level.

There have been many initiatives to reduce the contamination rate including direct feedback to the department by the Clinical Scientist, picture instructions within each blood culture pack, Induction training in the clinical training lab for newly qualified doctors, sign off books were trainers observe practice, acceptance of a blood culture policy and an ANTT web based training package, however these practices still don't appear to be embedded.



Action: IPCT to continue to monitor, provide training and work with the laboratory in assisting clinicians to reduce their contamination rates. Work with IT and the Training Dept. to verify ANTT® training is mandatory for doctors and nurses. **Due: Monthly monitoring and audit with continued training in Induction and Mandatory Training.**

Outbreaks of Norovirus and Influenza A

The table below records the Norovirus and Influenza outbreaks which occurred 30119-20

Month	Ward	Confirmed Cases	Lost/empty Bed Days
April 2019 Norovirus	14B	4	13
	9A	5	13
	15B	10	23
	9B	2	8
	14A	5	11
	7A	5	14
	9B	7	10
May 2019 Norovirus	7A	4	14
	14A	6	28
	9B	5	22
October 2019 Influenza A	14B	4	15
November 2019 Influenza A	7A	4	2
November 2019 Norovirus	14A	5	22
Total	**13**	**66**	**195**

The Norovirus outbreaks during the April and May were very significant causing a lot of disruption. During this time period there were daily outbreak meetings with added environmental and hand hygiene audits and a substantial increase in cleaning and disinfection by all staff, but in particularly the domestic staff.

It was evident at this time that the surrounding community within our catchment area were experiencing community outbreaks as evidenced by nursing/care home closures. Some of these residents were admitted to the hospital and transferred infection to others. Other sources of infection included: confused patients who didn't limit themselves to their own bed space or assigned toilet, patients who had symptoms on admission but their symptoms were thought to be due to other reasons apart from an infectious cause, relatives who were symptomatic in patients toilets or in some cases symptomatic in communal areas of the wards - these incidences led to transference on the wards as staff found it difficult to isolate all the affected patients.

All affected areas received enhanced cleaning with disinfectants, including use of the Ultra Violet (band C) disinfection units and Hydrogen Peroxide Vapour units. Increased signage was used to warn affected visitors to stay home and the local press and media were involved in warning people of the symptoms of Norovirus and how to respond if they became infected, within the hospital patients and relatives were given information sheets regarding Norovirus and how to keep safe. External agencies including CCGs, PHE, NHSI, NHS England and local authorities provided advice and were kept updated on the outbreaks.

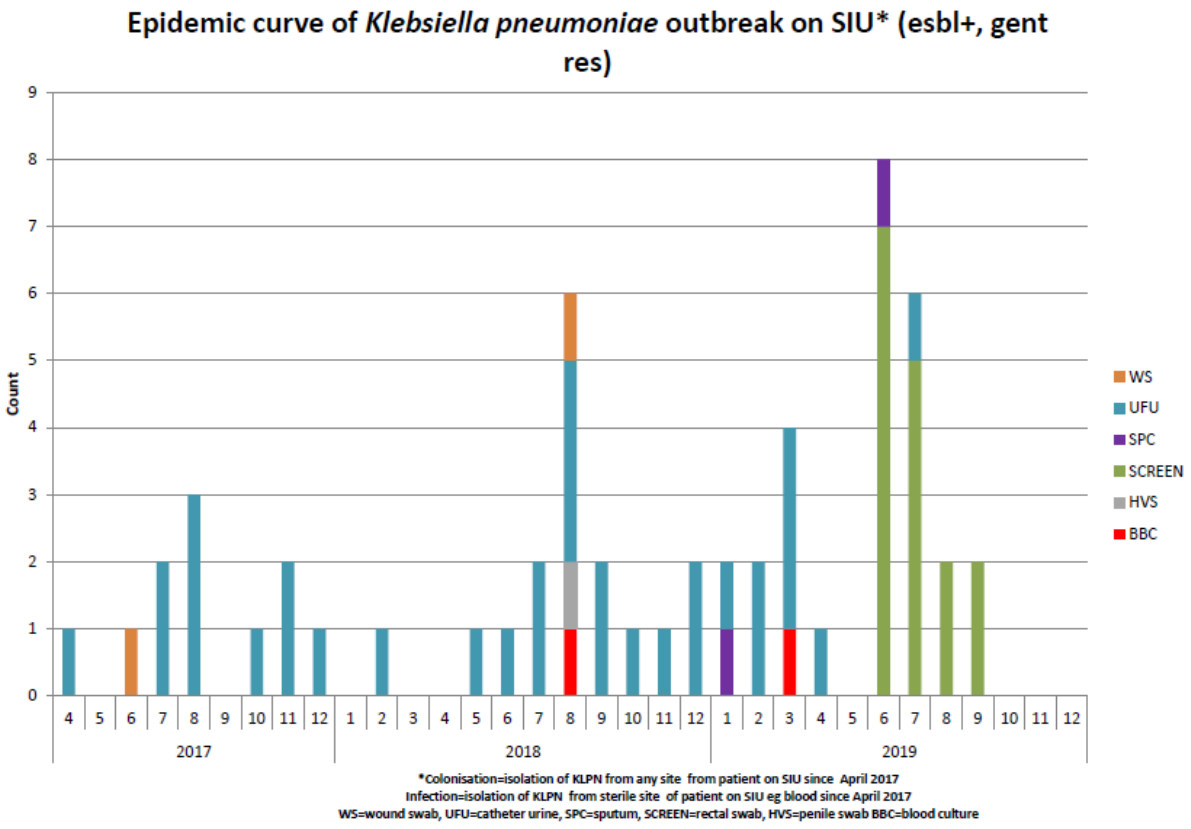
Lessons learned have been distributed throughout the Trust on posters, Trust News, the IPC Monthly Performance report and Mandatory and Induction training.

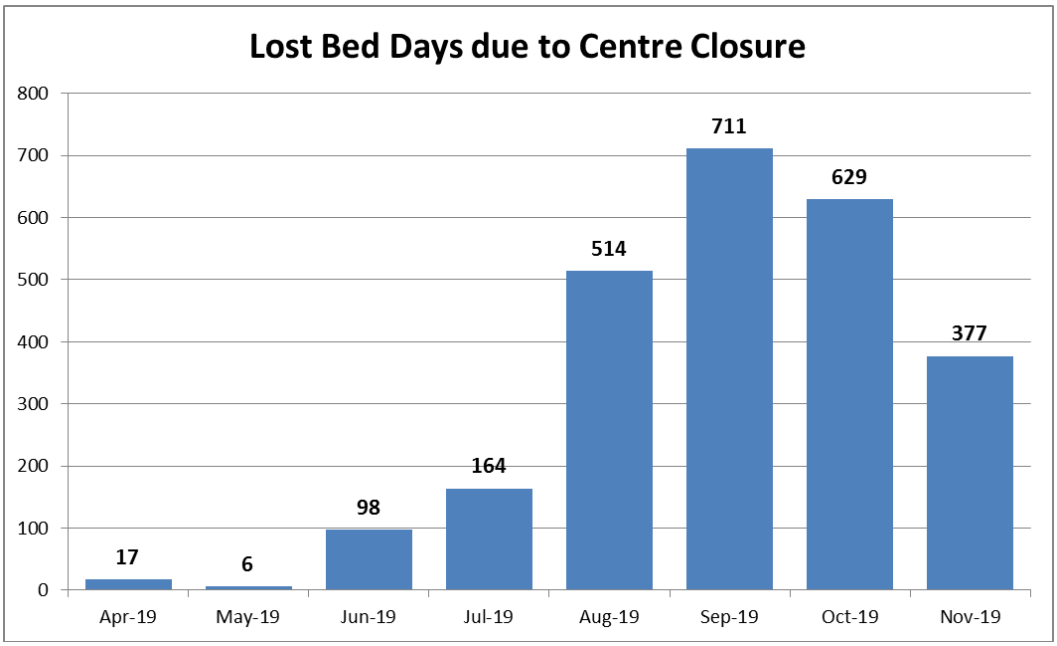
NWSIC Klebsiella ESBL Outbreak

Two bacteraemia were identified since August 2018 and a number of patients noted to have a similar gentamicin resistant ESBL+ve *K. pneumoniae*. Typing results revealed these to be of the same VNTR type suggesting a problem with acquisition and transmission of the organism on the unit. An initial outbreak meeting was held on 3.06.19 and the unit closed to admissions on 23.07.19 to allow various control measures and actions to be put in place.

This has led to extensive cleaning, enhancement of IPC procedures and refurbishment of the unit with particular attention to the areas which are likely to harbour and be a reservoir of *K. pneumoniae*. This process has meant closure of the unit to admissions for 3 months and subsequent increase in patients awaiting transfer. The ward continues to be monitored and patients screened and ongoing IPC and cleanliness audits.

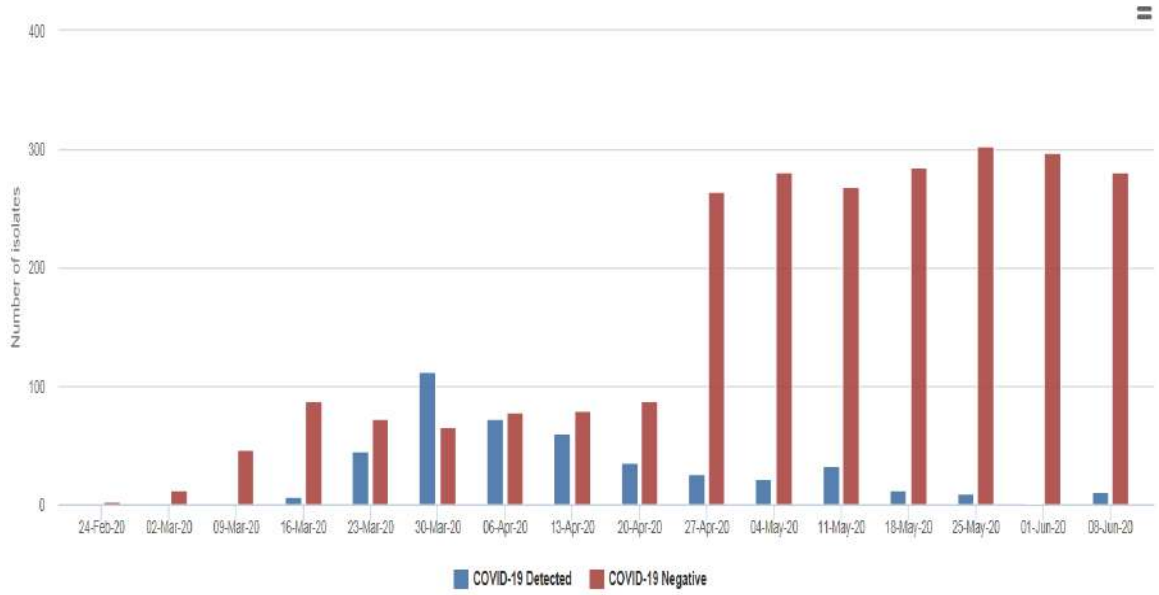
The chart below shows the numbers of patients testing positive for this organism and the sample sites. The 2nd chart reports the lost or empty bed days whilst the ward was being refurbished.





Coronavirus (COVID-19)

The bar chart below is a week by week comparison of patients who tested positive versus those who tested negative, this doesn't include staff screening or pre-op screening; duplicate positive or negative screens have been excluded.



Coronavirus has had an incredible impact to the world and country. Within the hospital the peak of the pandemic was in the last week of March with over a hundred patients testing positive in this week alone. As the pandemic progressed the IPCT was heavily involved in decision making and producing policies, SOPs and guidance as well as providing support and reassurance.

Gaps in Annual Programme and Actions

RCAs for Hospital Acquired C diff and Bacteraemia

Delays experienced in convening quorate RCAs.

Action: The IPCT, Risk and CBUs to review and streamline the process and establish timeframes for submission| **Due: 1/8/2020.**

Update: Continue to have difficulty with engagement, hence further meetings planned - need to ensure that the process is timely, meaningful and that learning is extracted and shared.

IPC Nurse Professional Development

Due to staff shortages caused by long term sickness and later due to increased work load due to COVID the IPC nurses have been unable to go on their normal educational program.

Action: The IPC nurses have picked up educational and development activities through local meetings, journals and teleconferences, however to allocate time to attend virtual or in person workshops or conferences specific to our roles | **Due: November 2020**

Update: Some conferences and regional workshops are now being planned in professional groups, hence need to book and reserve places.

HEAT/IPC Inspections

Previously issues with inspections not being quorate hence expanded inspection pool to include nurse managers as well as other senior nursing leaders. See appendix 3 for HEAT/IPC scores. With working more closely with Matrons in the IPC operational meetings it was decided that the Matrons should take ownership of their own areas with an IPC nurse

Action: Simplify HEAT inspections to use Matron of the area with an IPC nurse | **due: 1/4/20.**

Update: IPC Inspections with Matron and IPC nurse are more streamlined and effective; Any Estates or Facilities jobs are logged on the help desk.

IPC Policies

IPC policies are current and now include a Coronavirus policy; the IPC manual is being updated with new guidance

Action: Be aware of policies soon to be expiring such as the Influenza policy; IPC Matron to update IPC Manual with new guidance such as COVID | **Due: 1/9/2020.**

Update: The Influenza policy will be updated when the new guidance comes out probably in September and the updated manual segments just need insertion.

MRSA Pathway Audits

MRSA pathway audits continue to having missing documentation as reported on the IPC Monthly Performance reports. Previously the HONs were tasked with resolving these issues; however the Matrons probably have greater influence on the wards.

Action: Urgent Care and Planned Care CBU Matrons to report in the IPC Operational Meetings their actions if their respective ward audit scores are poor then provide assurance to the HONs | **Due: IPC Operational monthly meetings.**

Update: Matrons have taken on board assignments/actions from operational meetings, which should soon start to see some improvements**.**

Prompt Isolation of Patients with Bristol Stool Types 5-7

The figures for isolating patients with diarrhoea are based on patients who have tested positive for C diff antigen and toxin; when these patients are reviewed the IPCT determines whether they could have been isolated sooner as in when symptoms of diarrhoea started as opposed to waiting for the lab result to be returned.

Action: The pop up isolation pods may assist in some areas if an isolation room isn't readily available in addition to this improving patient flow and discharge planning so that the hospital is never too full to be able to make adjustments so that symptomatic patients can be isolated | **Due: IPCAG quarterly meetings.**

Update: improvement in this area continues to prove difficult to sustain mostly due to high capacity on the Southport site and limited number of side rooms. Going into the New Year the Planned and Urgent care Matrons will be reporting in the monthly IPC Operational meetings and considering actions for improvement. On an operational basis the Trust has patient flow meetings 3 times a day which includes input from the IPC team; in addition the IPC nurses now provide a 7 day service and so are better able to liaise with the Hospital Clinical Coordinators (bed managers) at weekends to facilitate appropriate isolation.

Compliance with Annual IPC Mandatory Training

A quarter of staff are out of compliance with annual IPC Mandatory Training.

Action: HONs and AMDs to facilitate staff attendance at mandatory training through Matrons, Managers and Clinical Leads | **due: ongoing**

Update: IPC mandatory training continues to be in the region of 75%.

Action: HONs through Matrons to make sure sufficient UV light boxes available for hand hygiene training | **due: 1/9/2020**

Update: Matrons have identified where UV light boxes are and also utilise IPC and light boxes when needed.

Action: IPCT to discuss other methods of training to facilitate learning – to meet with Education & Training Manager and consider options – during the Coronavirus pandemic much of the training went online; need to evaluate if this is a viable option | **Due: 1/9/2020**

Update: In meeting with training department staff additional training sessions have been organised for some staff groups and the IPC nurses provide training directly to Maternity, Paeds and Theatre staff.

Link Workers Attendance at Quarterly Link Workers Meetings

Limited attendance from wards at Link Workers Quarterly Meetings.

Actions: IPCT to feed back to HONs and Matrons attendance at meetings and HONs and Matrons to facilitate through Nurse Managers, Link Workers attendance at meetings | **Due: Feedback to IPCAG quarterly meetings**

Update: With recent changes to personnel will need to follow up in the Operational IPC meetings with the CBU Matrons and Managers. The IPC Information Officer has provided Matrons/Managers with lists of their Link Workers, to verify who's current and recruit new ones if any have terminated. .

Board Assurance Framework (BAF) and Audits

Due to the Coronavirus pandemic NHSE/I as part of their command and control function have provided a framework for Trusts to adhere to in 2020-21, hence the above IPC programme will be largely superseded.

Actions: Complete the Frame work and produce a method to audit the framework | **due: 1/9/2020**

Update: The BAF has already been completed and the audit (see appendix 4) has been submitted to "Perfect Ward" to be added to the current ward audits.

Appendices

Appendix 1

	Surveillance programme 2020-21	Lead	Frequency	Progress update
1.	Mandatory surveillance for MRSA bacteraemia	IPCT	Continuous	Reported Monthly
2.	Mandatory surveillance of *C. difficile*	IPCT	Continuous	Reported monthly
3	Participate in National mandatory surveillance of Orthopaedic SSI	Trauma Nurse	Continuous	Reported monthly
4	Mandatory surveillance for E coli, Klebsiella, and pseudomonas bacteraemia	IPCT	Continuous	Reported Monthly
5.	Continuous surveillance for MSSA bacteraemia	IPCT	Continuous	Reported monthly
6.	Alert organism and condition surveillance	IPCT	Daily	Completed daily; Review on ICNet
7.	All organism bacteraemia surveillance with infection rates by ward	IPCT	Continuous	Reported Monthly
8.	Enhanced Surveillance in Critical Care (Central Lines and Ventilator-associated pneumonia)	IPCT Critical Care Lead	Continuous	Reported monthly
9.	Inoculation incidents	Staff Health and Wellbeing	Continuous	Reported quarterly
10	Central line associated bacteraemia in non-critical care areas	IPCT	Continuous	Reported Monthly
11.	Invasive medical device prevalence for all wards	IPCT	Weekly	Reported monthly
12.	Quantitative assessment of commode cleanliness	IPCT	Weekly	Reported monthly
13.	Sepsis Mortality review	Executive Medical Director	Continuous	As required
14.	SSI Surveillance for Caesarean Sections	IPCT	Continuous	Reported

	(development of systems)	Head of Midwifery		monthly

Appendix 2

	Audit programme 2020-21	Lead	Frequency	Progress update
1.	Hand hygiene	IPCT Link practitioners	Monthly	Reported monthly
2.	MRSA screening compliance for elective & emergency admissions	IPCT	Monthly	Reported monthly
3.	Contamination of blood culture specimens	IPCT	Monthly	Reported monthly
4.	Compliance with MRSA Pathways	IPCT	Weekly	Reported monthly
5.	Compliance with C. difficile Pathways	IPCT	Weekly	Reported Monthly
6.	Hand gel availability	IPCT	Bi-weekly	Reported monthly
7.	Antibiotic audits	Antimicrobial Pharmacist	Monthly	Reported Monthly
9.	Compliance with cannula care plan	IPCT	6 monthly	Reported bi-annually
10.	Compliance with catheter care plan	IPCT	6 monthly	Reported bi-annually
11.	PPE audit	IPCT	monthly	Reported monthly

Appendix 3

HEAT INSPECTION SCORE CHART BY STANDARD - 2019

Ward	Date	Cleanliness of Ward Equipment	Patient Hygiene Areas	Ward departmental Furniture	Linen	Treatment Room Facilities	Decontam / Sluice	Hand Hygiene Facilities	Internal Decoration	Patient Toilets	Protective Clothing	Waste Disposal	Ward Station
F Ward	10/01/2019	3	N/A	3	2	2	2	2	1	3	2	3	3
Max Fax	01/01/2019	3	N/A	4	2	2	3	3	2	4	2	3	4
G Ward	28/02/2019	1	3	3	3	3	2	3	3	3	3	0	4
Delivery	28/02/2019	2	4	4	3	3	2	3	2	4	4	0	4
Critical Care	16/03/2019	3	4	3	4	3	3	3	2	4	3	3	2
Maternity	26/03/2019	2	3	3	3	2	2	2	3	3	4	3	3
Paeds AED	26/03/2019	3	3	1	4	3	4	3	1	4	4	4	3
15B	16/04/2019	1	4	2	3	3	4	3	2	4	3	3	3
11A	01/05/2019	1	4	Not assessed	1	4	3	4	3	4	4	3	1
15A	24/05/2019	1	3	2	2	1	1	1	2	2	3	2	4
11B	24/05/2019	0	4	3	3	2	1	1	0	2	3	1	1
SIU	14/06/2019	3	3	3	3	2	3	3	2	4	4	2	4
OPD, SDGH	12/07/2019	3	N/A	2	4	3	3	3	2	3	4	3	2
X-Ray ODGH	23/08/2019	3	N/A	1	4	2	3	2	1	4	4	3	3
OPD ODGH	25/10/2019	3	N/a	3	n/a	3	3	3	3	4	3	4	3
14B	06/11/2019	2	2	3	3	3	2	3	2	4	3	3	4
MAS	15/11/2019	3	3	2	3	3	2	0	3	4	4	3	4
NNU	15/11/2019	3	3	3	3	1	4	4	2	4	4	3	4
Treatment Centre	28/11/2019	2	N/A	4	4	1	3	2	3	4	3	3	4
7A	10/12/2019	0	1	2	0	2	0	1	0	2	4	0	4
H Ward	20/12/2019	3	3	3	4	3	4	3	3	4	4	3	4
Childrens Ward	20/12/2019	3	3	3	4	4	3	3	2	4	4	3	4
AVERAGE		2	3	3	3	3	3	3	2	4	3	3	3

HEAT INSPECTION SCORE CHART BY STANDARD - 2020

Ward	Date	Cleanliness of Ward Equipment	Patient Hygiene Areas	Ward departmental Furniture	Linen	Treatment Room Facilities	Decontam / Sluice	Hand Hygiene Facilities	Internal Decoration	Patient Toilets	Protective Clothing	Waste Disposal	Ward Station
Max Fax	10/01/2020	4	N/A	3	4	3	4	3	3	4	4	3	4
ENT OPD, ODGH	10/01/2020	3	N/A	3	3	3	N/A	3	2	4	4	3	4
EAU	15/01/2020	3	2	3	2	3	2	3	1	3	4	3	4
14A	15/01/2020	3	3	4	2	2	2	2	1	3	4	3	4
10B	28/01/2020	3	3	3	4	2	2	3	2	3	4	3	4
OBS	25/02/2020	1	3	4	3	3	3	3	3	3	3	2	3
MDU	25/02/2020	3	4	4	4	3	3	4	4	2	3	3	3
14A Re-Audit	03/03/2020	4	3	3	3	3	3	3	2	4	4	3	3
X-Ray SDGH	06/03/2020	2	n/a	2	4	1	n/a	3	1	4	4	3	4

KEY	Score
Excellent	4
Good	3
Average	2
Below Average	1
Poor	0

INFECTION PREVENTION & CONTROL AUDIT - 2019

Date	Area	Score %	Action Plan Received		
			Nursing	Facilities	Estates
29/01/2019	SIU	74	Yes		
02/02/2019	MAS	67	Yes		
04/02/2019	14A	69	09/08/2019		
05/02/2019	14B	68			
14/02/2019	Treatment Centre	89	Yes		
04/03/2019	7B	78	Yes		
07/03/2019	7A	76			
14/03/2019	Neonatal	82	09/05/2019		
27/03/2019	Childrens Ward	75	09/05/2019		
04/04/2019	H Ward	77	20/05/2019		
09/05/2019	ENT ODGH	70	08/08/2019	N/A	
14/05/2019	Theatre SDGH	87		N/A	
17/05/2019	Paeds Ward	84			
21/05/2019	ENT SDGH	78	28/01/2020	N/A	
29/05/2019	EAU	73	18/08/2019		
05/06/2019	10B	67	17/07/2019		
26/06/2019	9A - SSU	74	10/02/2020		
27/06/2019	14B	86			
28/06/2019	7A	71	22/07/2019	01/07/2019	Refurb
27/08/2019	9B - FESS	75			
10/09/2019	OBS Ward	73			
03/09/2019	SIU	90	REFURB	REFURB	REFURB
13/09/2019	SIU	89	REFURB	REFURB	REFURB
03/10/2019	AED	71	14/01/2020		
11/10/2019	SIU	99	REFURB	REFURB	REFURB
01/10/2019	X-Ray SDGH	71			
28/11/2019	14A	96		N/A	N/A
28/11/2019	Childrens Ward	83		N/A	N/A
28/11/2019	Paeds OPD	96		N/A	N/A
11/12/2019	SIU	95	REFURB	REFURB	REFURB
30/12/2019	SIU	96	REFURB	REFURB	REFURB

Key	
85 – 100%	Pass
70 – 84%	Caution
69% and below	Fail

INFECTION PREVENTION & CONTROL AUDIT - 2020

Date	Area	Speciality	%	Score	Action Plan Received		
					Nursing	Facilities	Estates
09/01/2020	Neonatal	Specialist Services	97	4	23/06/2020	N/A	
21/01/2020	NWRSIC	Planned Care	82	3	11/02/2020	04/02/2020	
21/01/2020	Netherton SHC		90	3		N/A	
21/01/2020	Houghton St SHC		93	3			N/A
21/01/2020	St.Hughs SHC		96	3		N/A	N/A
21/01/2020	Maghull SHC		74	2		N/A	N/A
21/01/2020	GUM		77	2		10/02/2020	
26/02/2020	E Ward	Planned Care	81	3		22/06/2020	

Key	Score	
92-100%	4	Excellent
81-91%	3	Good
73-80%	2	Average
51-72%	1	Below Average
less than 50%	0	Poor

KPI - compliance = 73% and over

Appendix 4

Perfect ward IPC audit

Ward _____ Auditor _____ Date _____

COVID-19 screens Adm & 5-7 days later	5 pts reviewed	Screens completed	%
Isolation Room Audit	Number of rooms used for isolation	How many with appropriate sign and if indicated door closed	%
	Number of pts isolated d/t MRSA	Number of Pts with MRSA with updated pathway	%
Staff 4 PPE questions 1. When would you wear gloves, mask and apron 2. When would you wear an FFP3 respirator 3. When wearing PPE when do you gel/wash your hands 4. When would you wear a face shield	5 staff	Number of staff: 4/4 correct ¾ correct 2/4 correct ¼ correct 0 correct	% % % % %
Isolation rooms deep cleaned and disinfected with H2O2 or UVC light	Number should have been disinfected	Actual number disinfected	%
Commode/equipment ATP pass	Pass	Fail	
Hand Hygiene/PPE	5 staff observed Hand Hygiene	Number compliant	%
	5 staff observed PPE	Number compliant	%
PPE availability	Masks, gloves, aprons, FFP3 respirators, face shields/safety glasses, gowns available	YES/NO	

Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 September 2020**
Agenda Item	**TB136/20**	**FOI Exempt**	**No**
Report Title	**Health and Safety Annual Report**		
Executive Lead	Therese Patten - Deputy CEO and Director of Strategy		
Lead Officer	John Buck - Head of Health, safety, Fire and Security		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The Trust's health and safety programme is based around standards that are designed to assist Trust to achieve and maintain compliance with the health and safety legislation.

Executive Summary

This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health and Safety
- Security Management
- Fire Safety

Recommendation

The Board is asked to receive this Annual Report.

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:**
John Buck	Therese Patten

Southport and Ormskirk Hospital NHS Trust

HEALTH and SAFETY, SECURITY and FIRE MANAGEMENT ANNUAL REPORT

1ST APRIL 2019 TO 31ST MARCH 2020

Mr J Buck
Head of Health, Safety, Security and Fire

Please Note: The information collated within this report has been obtained from historical information from DATIX and other sources as I the current Head of Health, Safety, Security and Fire was not working at the Trust at the time of this report time frame.

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1.0 BRIEF/EXECUTIVE REPORT DETAILS

This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health and Safety
- Security Management
- Fire Safety

The Trust's health and safety programme is based around standards that are designed to assist Trust to achieve and maintain compliance with the health and safety legislation.

Post	Current Officer	From 2020
Accountable Officer Health and Safety	Chief Executive	Chief Executive
Named Executive Director of Health and Safety	Director of Nursing, Midwifery, Therapies and Governance	Deputy Chief Executive and Director of Strategy
Security Management Director	Director of Finance	Director of Finance
Fire Safety	Director of Finance	Deputy Chief Executive and Director of Strategy

Day to day responsibility for maintaining health and safety in the Trust is embedded into operational management arrangements of the Trust.

On the 26th March 2020 Merseyside Fire & Rescue Authority served an Enforcement Notice on the Trust Chief Executive for Southport and Ormskirk NHS Trust. The Enforcement Notice was issued as the Authority considered that relevant persons within the Trust were unsafe in case of fire.

The Trust is required to remedy the matters contained within the schedule within a period of 6 months. A Fire Enforcement Notice Action Plan has been completed and approved by the Health and Safety Committee and submitted to Merseyside Fire and Rescue Service for review.

2.0 HEALTH, SAFETY SECURITY AND FIRE FORWARD PLAN 2020 – 2021

A comprehensive forward plan will be established for the period above to include the following areas of health, safety and Fire provision, please refer to appendix 1 which highlights the health and safety team forward plan key aims and objectives.

2.0 INTRODUCTION

This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health and Safety
- Security Management
- Fire Safety

The Trust's health and safety programme is based around standards that are designed to assist Trust to achieve and maintain compliance with the health and safety legislation.

This report looks back on a year of slow progress for the Trust with regard to the management of Health

and Safety. In May 2019 the Trust Head of Health and Fire produced a report highlighting the currents staffing levels covering various aspects of health and safety provision under the umbrella of health and safety Legislation including The Regulatory Reform (Fire Safety) Order.

The Trust has within its current staffing structure the following staff:

- X1 – (WTE) Head of Health, Safety, Security and Fire
- X1 - (WTE) Physical Risk Adviser
- X1 - (0.6 WTE) Physical Risk Adviser (Pro rata 22.5 HRS)

The current staffing provision highlighted above was under resourced and working mainly reactive rather than proactive to the Trusts health and safety hazards and risks associated to a healthcare environment and current health and safety Legislation.

This report also highlighted the proposed staffing provision below:

- X1 – (WTE) Head of Health, Safety, Security and Fire
- X1 - (WTE) Health and Safety Adviser (The Trust has now appointed this position)
- X1 - (WTE) Technical Fire Manager new position (Interim Senior Fire Safety Advisor appointed)
- X1 - (WTE) Security Manager (0.6 WTE) to (WTE)
- X1 – (WTE) Health and Safety Coordinator (to support and coordinate health and safety team) this is currently being covered by redeployment role.

The report also highlighted the consideration of the current Manual Handling Advisor to be relocated to fall under the umbrella of health and safety team.

The Trust has addressed two of these shortfalls with an interim Senior Fire Advisor and Health and Safety Coordinator. The Trust is currently in the process of transferring the Manual Handling Advisor over to the Health and Safety team.

The approach of identifying gaps and risks associated with any of the Health and Safety and Fire Regulations benefits the Trust in gaining a wider picture of Health and Safety compliance. This is achieved by undertaking health and safety Inspections and audits to identify any potential gaps within current Health, Safety and Fire provision and compliance.

The primary function of the Health, Safety Security and Fire team is to provide advice, support and assistance to all staff and managers in the Trust regarding health and safety, fire safety and security management.

Statutory accountability for health and safety in the Trust sits with the Chief Executive. Specific responsibilities are delegated to individual directors as follows:

Post	Current Officer	From 2020
Accountable Officer Health and Safety	Chief Executive	Chief Executive
Named Executive Director of Health and Safety	Director of Nursing, Midwifery, Therapies and Governance	Deputy Chief Executive and Director of Strategy
Security Management Director	Director of Finance	Director of Finance
Fire Safety	Director of Finance	Deputy Chief Executive and Director of Strategy

Day to day responsibility for maintaining health and safety in the Trust is embedded into operational management arrangements of the Trust.

4.0 STATUTORY FRAMEWORK

4.1 Primary UK Legislation

Within the United Kingdom, the primary legislation regarding health and safety at work is the Health and Safety at Work etc. Act 1974. This Act imposes specific duties on all employers with regard to ensuring the health safety and welfare of both employees and others who may be affected by the undertakings. The Act is supported by a large number of supporting regulations that relate to specific elements of Health and Safety.

In order to assist NHS Bodies, managing compliance with Health and Safety legislation, NHS Employers have previously developed a suite of standards regarding Workplace Health and Safety Standards. The domains of these standards will be used to report on health and safety activity during the period 1st April 2018 to 31st March 2019. The standards are split into domains, which cover the Management of Health and Safety and specific areas of health and safety risk that may occur in healthcare organisations.

5.0 HEALTH AND SAFETY SUPPORT

A requirement of the Management of Health and Safety at Work Regulations 1999 is that the Trust must have access to health and safety assistance. This was achieved as follows:

5.1 Health, Safety Security and Fire Team

The team comprises of specialist advisors in the field of health and safety, fire safety, and security management and was established in accordance with the Trust's statutory duties contained within the Management of Health and Safety at Work Regulations 1999. The regulations also require the Trust to ensure that the persons appointed are competent, through sufficient training, knowledge and experience, and that their competency is maintained.

The team works closely with colleagues from all areas of the Trust including, but not restricted to Infection Prevention and Control, Health and Wellbeing, Emergency Planning, Radiation Protection, Estates and Facilities and Education and Training Department. This co-working assists in facilitating a seamless approach across the Trust, thus avoiding conflicting advice and information.

5.2 Management of Health and Safety at Work Regulations 1999

The Management of Health and Safety at Work Regulations 1999 requires the Trust to employ competent person(s) in Health and Safety at Work. The Managers post is the lead "competent person", as required by the Management of Health and Safety at Work Regulations 1999.

The Health and Safety Department team currently does not have a dedicated qualified and competent Senior Fire Advisor as required by HTM 05 01 – Firecode Management of Fire Safety in Healthcare.

6.0 WORKPLACE HEALTH AND SAFETY STANDARDS

6.1 Policies

The Trust has a suite of policies regarding Health and Safety at Work and these are reviewed and monitored by the Health and Safety Committee.

During the period 1st April 2019 to 31st March 2020, there were no policies scheduled for review.

7.0 Central Alerting System (CAS)

During the 1st April 2019 to 31st March 2020 the Trust received 5 Estates and Facilities Alerts (EFA) which were applicable to this trust. These 5 alerts have been reviewed and actioned within the timeframe of the alert and a description of these alerts is highlighted below.

Reference	Issue Date	Description of Alert	Status	Progress	Deadline
EFA/2020/001	29-Jan-20	Allergens Issues – Food Safety in the NHS	Issued	Action Completed	12-Feb-21
EFA/2019/005	31-Oct-19	Issues with doorstops/door buffers.	Issued	Action Not Required	30-Oct-20
EFA/2019/004	19-Sep-19	Zebra printer Power Supply Units (PSU's): fire risk – product recall	Issued	Action Completed	21-Feb-21
EFN/2019/01	12-Jul-19	Energy Networks Association (ENA) Various DINs, SOPs and NeDERs, issued since May 2018	Issued	Action Completed	31-Oct-19
EFA/2019/003	11-Mar-19	Anti-ligature type curtain rail systems: Risks from incorrect installation or modification	Issued	Action Completed	11-Sep-19

7.1 Care Quality Commission (CQC) Inspection

In the July and August 2019 CQC visited the Trust to undertake a core services and well lead inspection. During their inspection the Inspectors highlighted actions relating to the substances that are hazardous to health being stored within Ward Sluice Rooms and also the security and safety of these chemicals/products and provided verbal and written confirmation that these areas required immediate attention. Following this advice provided by a CQC Inspector the Trust immediately undertook a Health and Safety audit. The outcome of the audit highlighted most areas not having the lockable hazardous chemical/product cupboards. The Trust purchased 26 lockable cupboards to address this breach of compliance.

8.0 Governance relating to Health and Safety

8.1 Accountability

There is board level responsibility for Health and Safety, this role was carried out by the Deputy Chief Executive and Director of Strategy.

The roles and responsibilities in relation to health and safety at all levels of the Trust are detailed in the Trust's Health and Safety Policy.

8.2 Quality and Safety Committee

The Trust has established a Quality and Safety Committee, which is a sub –committee of the Trust Board. This committee receives regular reports regarding the work of the Health and Safety Committee. The Quality and Safety Committee regularly reviews the Trust's Extreme level Risk Register, which includes health and safety risks.

8.3 Trust Health and Safety Committee

The Trust's Health and Safety Committee was established in accordance with the requirements of the Safety Representatives and Safety Committee Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996**.**

The Health and Safety Committee is a subcommittee of the Trust's Quality and Safety Committee, which in turn reports to Trust Board.

The Terms of Reference for the Health and Safety Committee requires representatives from; management, Staff Side Representatives and Specialist Advisors and these are reviewed annually.

During the period 1st April 2019 to 31st March 2020, the Trust's Health and Safety Committee met on the following dates:

Month	Date Time	Location	Papers for meeting Deadline
2019-2020			
April	Tuesday 26th 9:00 – 11:00 am	Boardroom, CMO, SDGH	Monday 29th April
May	Friday 24th 9:30 – 11:30 am	Seminar Room Clinical Education	Tuesday 14th May
July	Friday 5th 10:00 – 12:00 am	Meeting Room Clinical Education	Monday 17th June
September	Friday 20th 12:00 – 14:00 pm	Seminar Room Clinical Education	Monday 2nd September
November	Friday 22nd 10:00 – 12:00 pm	Boardroom, CMO, SDGH	Friday 1st November
January	Friday 31st 10:00 – 12:00 pm	Meeting Room Clinical Education SDGH	Friday 10th January
March	Wednesday 25th 10:00 – 11am	Boardroom CMO Extra Ordinary Meeting	

Meetings of the Health and Safety Committee they have standing agenda items for Health, Safety, Security and Fire issues as highlighted within the list below, this list is not an exhausted list.

- Accident, incident statistics, progress with completion of audits and progress against training requirements.
- RIDDOR reportable incidents to the HSE
- Central Alert System (CAS) Alerts

- Fire Activation Alerts which have occurred at the Trust
- Any issues that require escalation to the Quality and Safety Committee are identified at the Health and Safety Committee.
- Any relevant Policies which may require review
- Quarterly reports covering Health, Safety, Security and Fire
- Health and Safety reports relating to Health, Safety, Security and Fire

Items requiring escalation are documented on the AAA report and disseminated to the relevant Quality and Safety Committee.

The meetings of the Health and Safety Committee provide assurance to the Trust is complying with statutory requirements in relation to consultation with staff side health and safety representatives.

9.0 Joint Working with Other Employers

The Management of Health and Safety at Work Regulations 1999 requires the Trust to co-operate with other employers who have employees working on Trust sites.

In the Trust there are employees from the following NHS organisations which includes St Helens and Knowsley Hospitals.

The staff concerned who are employed in the Pathology Service, which is managed by St Helens and Knowsley Hospitals NHS Trust.

9.1 Contractors

The Health Safety Team support the Trust's Capital Project Manager(s) to ensure the safe completion of capital developments on Trust property.

This practice ensures information is reviewed and shared with other parties and that awareness is raised with regard to specific risks that may affect the operations of either the Trust and/or the third party.

9.2 Safety Representatives

During the last year Staff Health and Safety Representatives attended the Trust Health and Safety Committee. The team have ensured that whenever available, Staff Health and Safety Representatives participated in Health and Safety audits, around the Trust. The joint approach towards completion of health and safety audits will be continued, by the Health and Safety Team during the current year.

9.3 Health and Safety Risk Assessments

All risks relating to health and safety are managed in line with the Trust's processes for risk assessment and risk registers.

All Health and Safety Risks should be recorded using the Risk Assessment Template which is available within the appendices Risk Assessment Risk Registers Policy (RM 26).

Register, and are reviewed and managed by the Clinical Business Units of the Trust, through their Governance structures.

All risks relating to health and safety are reviewed in line with the frequency identified in the Trust's Risk Management Strategy and are reported to and monitored as part of the governance frameworks in the Business Units all risk assessments should be reviewed and approved by the CBU'S prior to being uploaded onto the Risk Register (this is dependent on the risk rating of the assessment).

The Health and Safety Team maintain an over view of all health and safety related risks, and provide advice, support and assistance to managers and staff regarding assessment and ongoing management of risks.

In July 2019 the Health and Safety Team visited clinical areas to undertake a Ligature Risk Assessment and the action from the risk assessment was too provide all clinical areas with a safety Ligature cutting tools and these are currently stored on all resuscitation trolleys.

10.0 Health and Safety Training

10.1 The Health Safety Security and Fire Team delivers Health and Safety training in the Trust in line with the Trust's Policy for Mandatory and Induction Training.

The training activity that was completed during the period 1st April 2019 to 31st March 2020 was as identified below with the %compliance highlighted.

	Require competence	Meet requirement	Do not meet requirement	Apr-19	Require competence	Meet requirement	Do not meet requirement	May-19	Require competence	Meet requirement	Do not meet requirement	Jun-19	Require competence
Fire Safety	2826	2424	402	85.77%	2869	2450	419	85.40%	2878	2465	413	85.65%	2857
Local Fire	2826	2222	604	78.63%	2869	2239	630	78.04%	2878	2223	655	77.24%	2857
H, S & Welfare	2826	2546	280	90.09%	2869	2569	300	89.54%	2878	2584	294	89.78%	2857
Conflict Resolution	2322	2114	208	91.04%	2322	2122	200	91.39%	2325	2115	210	90.97%	2315

The areas of training which relate to Health and Safety are as follows:

- Health, Safety and Welfare
- Fire Safety
- Manual Handling
- Fire Safety for Managers
- Risk Assessment
- Conflict Resolution
- Trust Induction
- COSHH

In order to plan training delivery, the Health Safety Security and Fire team used information supplied by the Education and Training team, which identified the likely demand for each subject area throughout the year.

Due to fluctuating attendance during the year, it was necessary to schedule and provide additional Conflict Resolution training.

The attendance at all health and safety related training is monitored by the Health Safety Security and Fire team to ensure the best use of trainer time.

On March 2020 all Trust training was suspended due to the COVID-19 pandemic and dates have not be rescheduled for the restart of training.

11.0 Health and Safety Audits

Due to lack of resources within the Health Safety Team during the period 1st April 2019 to 31st March 2020, audits were undertaken for COSHH.

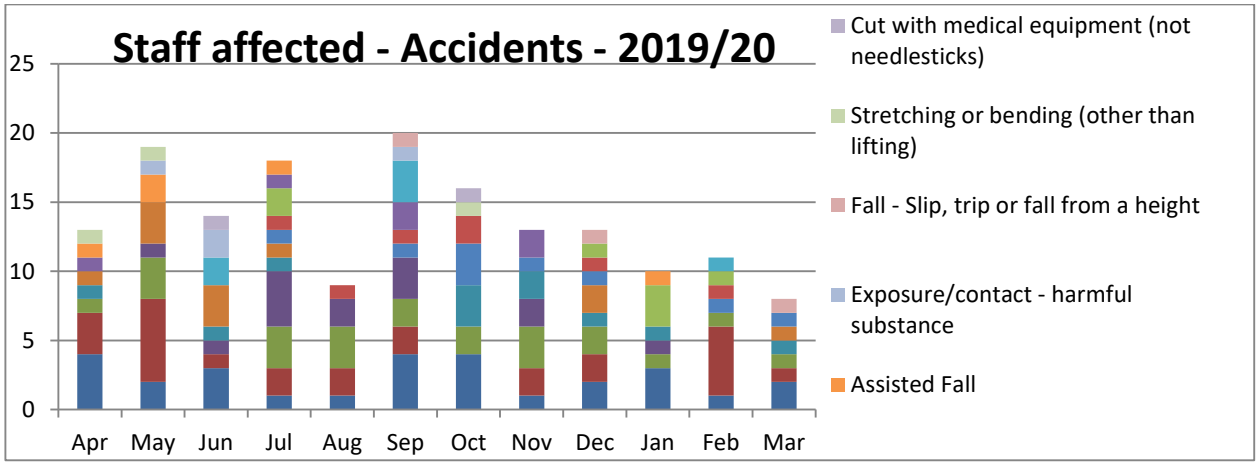
12.0 Health and Safety Incidents

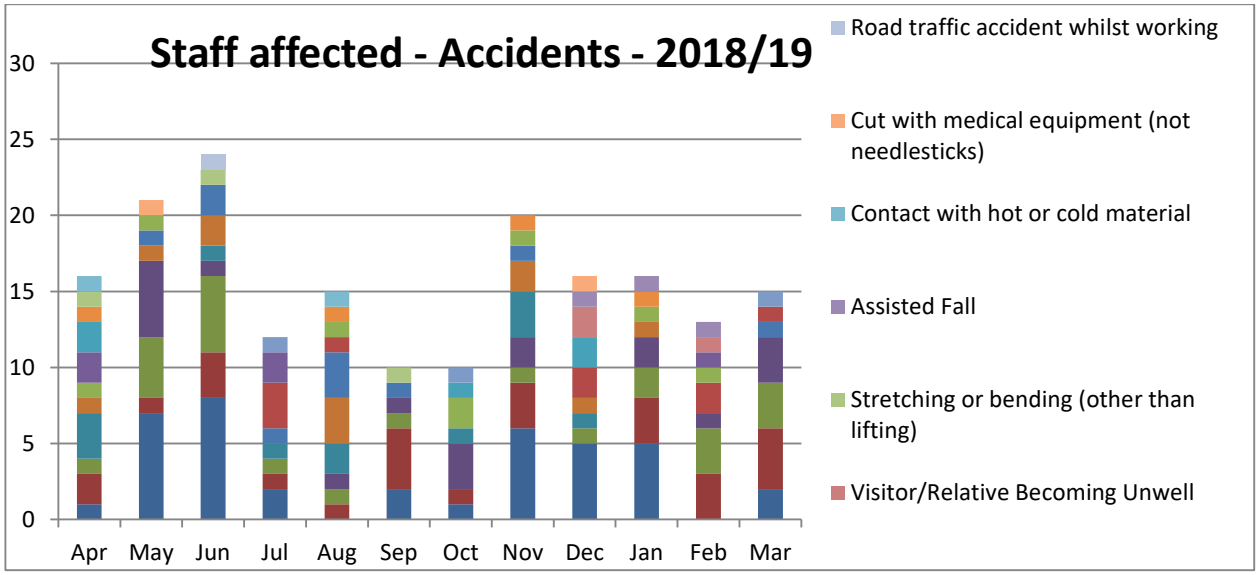
During the period 1st April 2019 to 31st March 2020, a total of 987 health and safety incidents were reported in the Trust. This was a reduction from the previous year's total of 193 and this may have been due to the Coronavirus.

These incidents include incidents that affected both patients and visitors.

12.1 Staff Incidents 2019/20

During this period there were a total of 164 accidents which involved Trust employees as identified by the categories by month within the table below.





The 5 most common causes of these incidents were as follows:

Category	2018/19	2019/20
Used/Dirty Needlestick/sharps/scalpel injury	**39**	**28**
Fall – Slip, trip or fall on the same level	**26**	**26**
Lifting or moving a patient or other person	**23**	**22**
Collision with an object or person – no fall	**19**	**14**
Lifting or moving an object or a load	**12**	**11**

Used / Dirty Needle Stick / Sharps / Scalpel Injury still remains the top highest reported incident by category but this figure has fallen from 20.74% to 17.07%. The table above highlights the number of incidents for both 2018/19 and 2019/20.

The Trust has invested in the use of safety needles, for staff which have protective covers fitted that should be fitted to the needle after use.

While there is evidence of these covers being used, it has clearly not solved the problem of needle stick injuries being sustained by Trust employees.

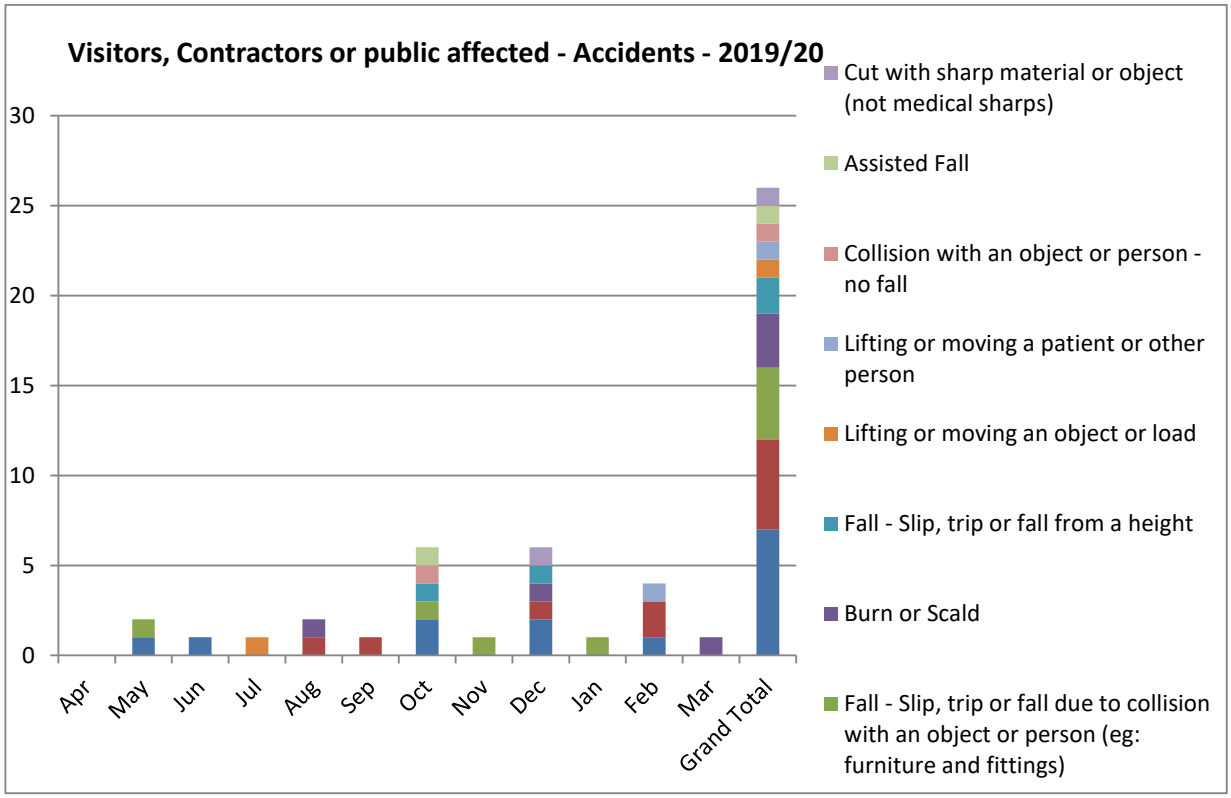
During the period 1st April 2019 to 31st March 2020; of the top 5 reportable incidents there has been a slight increase over this period compared to the previous year. All incidents were reviewed to identify possible preventative action to prevent further incidents.

The Health Safety Security and Fire Team review staff incidents, in order to ensure that satisfactory action is taken to prevent further incidents and all required evidence is collated regarding incidents. This will feature on the work plan for 2019 / 2020.

12.2 Health and Safety Incidents which affected Visitors, Contractors and the Pubic

The overall trend for incident which affected Visitors, Contractors and the Public is as follows:

Visitors, contractors or Public affected – Accidents – 2019/20														
Sub Category	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**	**%**
Fall – Slip, trip or fall on the same level		1	1				2		2		1		**7**	**26.92%**
Visitor/Relative Becoming Unwell					1	1			1		2		**5**	**19.23%**
Fall – Slip, trip or fall due to collision with an object or person (eg: furniture and fittings)		1					1	1		1			**4**	**15.38%**
Burn or Scald					1				1			1	**3**	**11.54%**
Fall – Slip, trip or fall from a height							1		1				**2**	**7.69%**
Lifting or moving an object or load				1									**1**	**3.85%**
Lifting or moving a patient or other person											1		**1**	**3.85%**
Collision with an object or person – no fall							1						**1**	**3.85%**
Assisted Fall							1						**1**	**3.85%**
Cut with sharp material or object (not medical sharps)									1				**1**	**3.85%**
Grand Total	**0**	**2**	**1**	**1**	**2**	**1**	**6**	**1**	**6**	**1**	**4**	**1**	**26**	



13.0 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 – Reportable Incidents

During the period 1st April 2018 to 31st March 2019, the Trust had 16 incidents and for the same period of 2019 to 2020 the Trust had 14 incidents reported to the Health and Safety Department and these were subsequently reported to the Health and Safety Executive as required by RIDDOR. (See table below).

These RIDDOR incidents have been broken down by category as highlighted in the tables below 2018/2019.

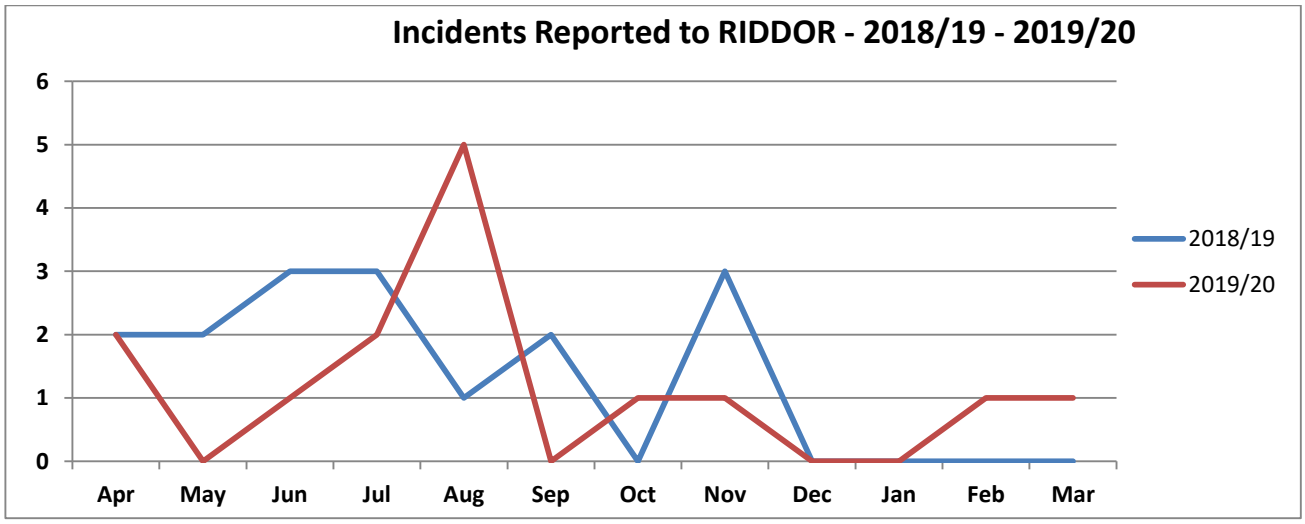
RIDDOR Accident Types 2018/2019												
	2018									2019		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Another kind of accident/Unsure	0	0	1	1	0	1	0	0	0	0	0	0
Hit by a moving, flying or falling object	0	1	0	0	0	0	0	0	0	0	0	0
Hit something fixed or stationary	0	0	1	0	0	1	1	0	0	0	0	0
Injured while handling, lifting or carrying	1	0	1	0	0	0	0	1	0	0	0	2
Slipped, tripped or fell on the same level	3	0	0	1	1	0	0	1	0	0	0	0

These RIDDOR incidents have been broken down by category as highlighted in the tables below 2019/2020.

RIDDOR Accident Types 2019/20												
	2019									2020		
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Slipped, tripped or fell on the same level				2	3		1	1				
Injured while handling, lifting or carrying	1		1		2							1
Hit something fixed or stationary	1											
Physically assaulted by a person											1	
Grand Total	**2**	**0**	**1**	**2**	**5**	**0**	**1**	**1**	**0**	**0**	**1**	**1**

The table low highlights the total numbers for the 2 years which is a reduction of 2 from the previous year.

RIDDOR													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
2018/19	2	2	3	3	1	2	0	3	0	0	0	0	**16**
2019/20	2	0	1	2	5	0	1	1	0	0	1	1	**14**



All reportable incidents are fully investigated by the Health and Safety Team and the report and action plan is produced.

13.1 Health and Safety Executive Interventions

During the period 1st April 2019 to 31st March 2020, there were no interventions carried out in the Trust by the Health and Safety Executive**.**

13.2 COVID-19 Environmental Risk Assessment

In April 2020 the Deputy Chief Executive and Director of Strategy commissioned a task and finish group (SWAT Team) to implement HM Government CPVOD-19 guidance. This group included various stakeholders throughout the Trust to undertake a COVID-19 Risk Assessment to ensure compliance with social distancing etc.

Each department within Estates, Facilities, Health and Safety and Infection Prevention nominated a representative whose responsibility to implement any actions that where identified on the risk assessments. The Swat team would review each departments risk assessment and then arrange a site visit with the manager of each area.

The manager would then be able to update their risk assessment following the site visit with any of the recommendations made by the Swat team. The actions would be taken from the risk assessments and added to a tracker system so the Swat Team leader could monitor how the actions were progressing.

An example of the kind of actions that have been carried out are screens on reception desks, tills and work stations, improved spacing of desks, additional hand sanitisers stations, one-way systems, improved monitoring of cleaning supplies and equipment and increased cleaning of areas.

The Corporate Management Office had comprehensive COVID-19 Risk Assessment which highlighted fundamental high risks which involved a full reconfiguration. To comply with this the CMO desk capacity had to be reduced from 250 to 100 and a one way system was introduced.

The alterations meant that staff where always a minimum of 2m between each other and therefore the area was COVID-19 secure the fire evacuation plan was improved and the fire risk was reduced. All areas the Swat team visited now have up to date risk assessments and all have had risk mitigating work carried out, this work is still ongoing.

13.3 Slips and Trips

The Trust has a Falls Prevention Policy in place, which addresses patient specific and general falls prevention.

Falls prevention utilises risk assessments that are either specific to individual patients or relate to the environment. This is a requirement of the Management of Health and Safety at and Work Regulations 1999.

During the period 1st April 2019 to 31st March 2020, the Trust's policies for falls prevention remained in force and falls incidents involving patients were reviewed and discussed at the Trust's Falls Group meetings, which was attended by a representative of the Risk Management Department.

The Health and Safety Department has ensured that regular reports are made to the Falls Group, regarding reported falls incidents as part of the health and safety quarterly reports shared and monitored by the Trust Health and Safety Committee.

Falls involving Trust staff were covered in reports to the Trust's Health and Safety Committee that were prepared by the Risk Management Department.

All falls incidents that were reviewed on the Datix Incident Reporting system were reviewed by the Risk Management Department, to ensure all possible action was taken to prevent further incidents.

Incident investigations regarding patient falls identified that the Trust's Falls Care Bundle was not always being used as tool to prevent falls. This has led to ongoing initiatives in the Urgent Care and Planned Care CBUs to improve the use of the Falls Care Bundle and further reduce the number of falls in the Trust.

This work will continue during the coming year to ensure that all possible action is being taken to reduce the risk of patient falls.

13.4 Manual Handling

The Trust has a Manual Handling Policy in place, which identifies how the risk of harm from manual handling is controlled, which is based on the requirements of the Manual Handling Operations Regulations 1999.

The Trust has in place processes for assessing the manual handling requirements of individual patients, which is a key part of the clinical management of each patient.

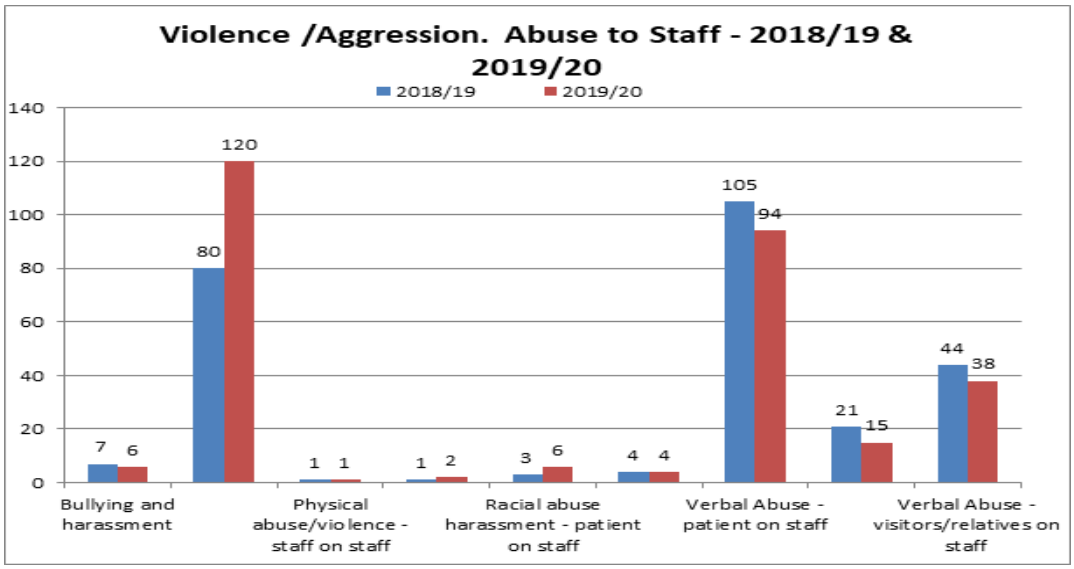
The Trust has maintained the existing provision of manual handling aids, which are provided to reduce the risk of harm to staff and patients. The Manual Handling role is currently under review in light of the resent retirement of the Trust Manual Handling Advisor. The Trust is currently considering this role falling under the remit and management of the Health and Safety Team as the Manual Handling Regulation fall under the umbrella of health and safety Legislation.

13.5 Violence and Aggression

The Trust has an established Policy for the Management of Violence and Aggression. The risk of violence has been controlled using risk assessment methodologies, which relate to the general risk of violence or patient specific risks. This allows the Trust to meets its obligations from the Management of Health and Safety at Work Regulations 1999.

During the period 1st April 2019 to 31st March 2020 there were 286 incidents of violence/aggression/abuse to staff, which is an increase of 20 from the previous year's figure of 266 as highlighted below.

Violence and Aggression	2018/19	2019/20
Bullying and harassment	7	6
Physical abuse/violence – patient on staff	80	120
Physical abuse/violence - staff on staff	1	1
Physical abuse/violence - visitors/relatives on staff	1	2
Racial abuse harassment - patient on staff	3	6
Sexual abuse harassment - patient on staff	4	4
Verbal Abuse - patient on staff	105	94
Verbal Abuse - staff on staff	21	15
Verbal Abuse - visitors/relatives on staff	44	38
Grand Total	**266**	**286**



13.6 Security Training

The Trust's training provision regarding violence and aggression has focussed on Conflict Resolution, during the period 1St April 2019 to 31st March 2020 the Trust delivered training to staff and is currently 91% compliant.

In April 2016 the Trust introduced a Security Service, to act as a deterrent to offenders and provide support to staff involved in managing violent patients during high risk periods. The service provides 24 hour cover 7 days a week at SDGH and 7 days a week between the hours of 4.00 PM to 12.00 AM the Health Safety Security and Fire Team continue to work closely with the service. The provision of security guards is currently out for tender.

13.7 Lone Working

Lone working is risk managed under the terms of the Management of Health and Safety at Work Regulations 1999. The Trust has an established Policy for the Management of Lone Working. This is based on use of risk assessment to identify and control risks. Lone work scenarios are recorded on the Trust risk register and are reviewed as part of operational risk management and health and safety audits. The risks regarding lone working are monitored by the Health Safety Security and Fire Team.

13.8 Stress

While there is no specific law relating to Stress, the Trust is required to assess and manage this risk as per regulation 5 of the Management of Health and Safety at Work Regulations 1999. To achieve this, a Stress risk assessment methodology is contained in the Trust's Policy for the Management of Occupational Stress. Stress has been managed as part of the Trust's Health and Well Being arrangements.

Stress risk assessments were managed as part of the Trust's Governance processes and risks were recorded on the risk register, and monitored through the governance frame work in each of the Business Units and falls under the HR Department.

13.9 Control of Substance Hazardous Health (COSHH)

The Trust has a Policy in place for control of substances hazardous to Health (COSHH). The policy which is based on the requirements of the Control of Substances Hazardous to Health Regulations 2002,

and requires all departments to maintain an inventory of hazardous substances, and to carry out COSHH risk assessments for those substances.

The Health Safety Security and Fire Team monitor compliance with this as part of departmental health and safety audits, the findings of which are reported to and monitored by the Trust's Health and Safety Committee.

The Trust provides health surveillance to groups of staff who are exposed to substances that may have an adverse effect on their health and safety, this process has been delivered by the Health and Well Being Service.

Resent Incidents have highlighted the lack of COSHH training within specific areas of the Trust and the Health and Safety Manager is currently in the process of producing a bespoke COSHH training pack specifically for Theatres and on completion all Theatre staff will be trained.

13.10 Management of Sharps

There are specific requirements regarding sharps that arise from the Health and Safety (Sharp Instruments in Health Care) Regulations 2013. This requires that "safer" sharp instruments should be used in healthcare organisations.

The Trust has been using sharp instruments that are designed to be "safer", due to the use of protective covers that encase the needle following use. The use of these safer sharps is monitored as it has been noted that incidents are continuing to occur in the Trust. There have been occasional incident reports which suggested that the covers were not effective. As a result of investigations, further training was provided to staff regarding the use of the safety covers.

The Health Safety Security and Fire Team review reports of all sharps incidents, in the Trust, and will continue to monitor this during the period 1st April 2019 to 31st March 2020.

13.11 Work Equipment

All work equipment that is purchased by the Trust, must be suitable for its intended use. The Trust has processes in place to ensure that high risk equipment such as medical devices is fit for purpose, and is reviewed by key staff such as the infection control team. This allowed the Trust to demonstrate that it is following the requirements of the Provision and Use of Work Equipment Regulations (PUWER) 1998.

The Risk Management Department is represented at the Trust's Capital Investment Group and Medical Devices Committee which oversee requests for new equipment. This ensures that risk is a key element of the process for replacing equipment.

13.12 Display Screen Equipment

The Trust has policy for Display Screen Equipment, which identifies standards for all elements of workstations. The policy also provides the process that can be used to carry out work station assessments. This allows the Trust to discharge it's duties under the Health and Safety (Display Screen Equipment) Regulations 1992.

The Health Safety Security and Fire Team monitor the completion of Display Screen Equipment work station assessments, as part of health and safety audits that are carried out in the Trust.

Compliance with Work station safety will continue to be monitored as part of Health and Safety audits carried out by the Health and Safety Department and manual Handling Advisor.

13.13 Legionella

The management of the risk posed by legionella is covered by the requirements of the Control of Substances Hazardous to Health Regulations 2002.

This requires the Trust to carry out risk assessments of water supply systems, to identify and address risks. This work is carried out by an external agency, and the findings are used to identify requirements for works, to reduce risk in the water infrastructure.

The findings of legionella risk assessments are over seen by the Trust's Water Safety Committee.

This is managed by the Facilities Management Team, who have ensured that testing for legionella is carried out in the Trust.

The Health Safety Security and Fire Team is represented at the Water Safety Committee, and will continue to play an active role in ensuring that all possible steps are taken to reduce the risk of legionella.

13.14 Asbestos

The Trust's arrangements for management of asbestos are detailed in the Control of Asbestos Policy, the content of which sets out the Trust's arrangements for complying with the Control of Asbestos Regulations 2012.

The Trust maintains registers of all asbestos in the Estates Department(s) on each hospital site. In order to inform the content of the register surveys of the Trust estate have been carried out by competent surveyors.

The Health Safety Security and Fire Team is consulted regarding capital projects that could involve disturbing encased asbestos, a scheme that is currently being implemented relates to improvement of fire compartmentation at SDGH. The planning of this scheme involved sharing with the contractor's asbestos surveys for affected areas of the site.

13.15 Electricity

Electrical safety is covered by the Health and Safety at Work Act, Management of Health and Safety at Work Regulations and Electricity at Works Regulations.

The maintenance and testing of all electrical systems has been carried out by the Facilities Management Teams.

The Estates Department on both sites have ensured that portable appliance testing (PAT) has been tested during health and safety audits. All equipment checked was found to have in date testing.

13.16 Management of Contractors

The activities of contractors are subject to controls that arise from the Management of Health and Safety at Work Regulations and the Construction, Design and Management Regulations (CDM) 2007.

Contractors who are deployed on Trust property for the purposes of Capital Projects and maintenance are controlled by the Facilities Department. When projects fall under the remit of the CDM Regulations, the Facilities Management Team has appointed competent external advisors, who have registered the schemes with the Health and Safety Executive.

For schemes carried out during the last year, the Risk Management Department have maintained contact with contractors and external advisors appointed by the Trust. This has ensured that the Trust can be assured regarding the safe delivery of projects.

13.17 Workplace Temperature

Maintaining Thermal Comfort in the workplace is a requirement of the Workplace (Health, Safety and Welfare) Regulations 1992**.** The ability for staff to maintain thermal comfort, by the use of portable equipment such as fans is checked during health and safety audits etc.

The impact of and the extremes of weather are considered as part of the Trust Emergency Planning arrangements, which are overseen by the Resilience Group. The Physical Risk Manager is a member of the Resilience Group. The Risk Management Department have worked with staff Health and Safety representatives to develop a standard operating procedure for thermal Comfort. This will provide a structured approach to management of thermal comfort in the Trust.

13.18 First Aid

First Aid provision is covered by the Health and Safety (First Aid) Regulation 1981. This requires the Trust to have arrangements in place for staff to access first aid, it also indicates that qualified Doctors and Nurses can administer first Aid.

During the last year the Health Safety Security and Fire Team in liaison with the Clinical business Units have reviewed provision in the Trust.

First Aid arrangements have been monitored by the Risk Management Department as part of health and safety audits, this process will continue during the current year.

13.19 New and Expectant Mothers

The Trust has legal obligations arising from the Management of Health and Safety at Work Regulations 1999, towards any employees who are expectant of new mothers. This requires the Trust to carry out an assessment of risks, in relation to the employee's normal employment and to take action to reduce risks.

This has been carried out by departmental managers using a methodology the Health Safety Security and Fire Team has previously developed to meet the requirement to assess risk in relation to new / expectant mothers.

14.0 SECURITY MANAGEMENT

During the period of 1st April 2019 to 31st March 2020 the Trust received via DATIX 144 which is a reduction of 21 compared to the previous year 2018/2019.

Security Incidents													
Period	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2018/19	9	15	17	10	7	10	18	16	24	11	14	14	**165**
2019/20	16	13	17	16	8	13	11	12	11	10	12	5	**144**

The table below highlights the monthly incidents by sub-category.

Security Incidents by Sub-Category 2019/20														
Security by Sub-Category	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**	**%**
Loss/Theft - personal property	4	4	5	6	4	4	3	5	3	4	4	1	**47**	**32.6%**
Unsecured areas, doors, windows	1	3	2	1		3	1	2	1	2	1	1	**18**	**12.5%**
Intrusion/trespass	2		2	2		1	3	1	1			2	**14**	**9.7%**
Assistance calls	3	1	2	1			2		2	2	1		**14**	**9.7%**
Public disorder	1	1	3		1	2				1	1		**10**	**6.9%**
Unlawful use of controlled substances in hospital	4			2					1		2		**9**	**6.3%**
Keys lost / unaccounted for		1	1	1	2			1	1		1		**8**	**5.6%**
System failures			1	1	1	1	1	1	1				**7**	**4.9%**
Loss/Theft - trust property	1	2	1			2							**6**	**4.2%**
Criminal damage/vandalism to hospital property								1	1	1			**3**	**2.1%**
Lost SMART card/ID Badge				1			1					1	**3**	**2.1%**
Intruder alarm				1				1					**2**	**1.4%**
Damage to vehicle											1		**1**	**0.7%**
Lost and found property											1		**1**	**0.7%**
Loss/Theft - vehicle/bicycle/other		1											**1**	**0.7%**
Grand Total	**16**	**13**	**17**	**16**	**8**	**13**	**11**	**12**	**11**	**10**	**12**	**5**	**144**	**100.0%**

14.1 Security Management Function

14.2 The Local Security Management Specialist's (LSMS) overall objective in the last reporting year has been to deliver an environment that is safe and secure concentrating on the Four Key Sections of NHS Protects' "Standards for Providers":

14.3 The Four Key Sections are:-

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

14.4 Security Management Standards

The standards that were developed by NHS Protect for providers of NHS services remain in place as it is a requirement that all providers of NHS services, comply with the standards.

A requirement of this is that an annual self-assessment against the standards is carried out, the Trust carried out this assessment in November 2019.

The findings of this were as follows:

Domain	Outcome in November 2018	Outcome in November 2020
Strategic Governance	Green	Green
Inform and involve	Green	Green
Prevent and Deter	Amber	Amber
Hold to Account	Green	Green

Rating	Descriptor
Green	There are outcomes that demonstrate that the impact of the work is being monitored.
Amber	Compliance with the standard but there is little or no evidence of the impact of the work being monitored.
Red	A risk has been taken but no / very little action has been taken.

14.5 Reporting Arrangements

The Health Safety Security and Fire Team reported security management's issues as follows during the period 1st April 2019 to 31st March 2020.

14.6 Trust Security Service

The Trust's is currently using the services of an external Security provider for our Security Guards. The service consists of 2 guards on each site who are tasked with carrying out regular patrols of the hospitals, to provide deterrence to potential offenders and support to staff in dealing with any violent incidents.

The service operated as follows:

- SDGH – 24 Hours a day 7 Days a week
- ODGH – 16.00 till 24.00

14.7 Lockdown

In order to effectively manage on site emergencies it may be necessary to implement a partial / full lock down of an entire hospital site. In order to achieve this, the access control infra-structure has now been enhanced to facilitate automatic lock down of all doors on the access control system.

The Health Safety Security and Fire Team have prepared a policy for Lockdown, which was agreed by the Trust's Resilience Group.

14.8 Security Audits

Due to a lack of resources security audits were not updated for this period 1st April 2019 to 31st March 2020.

14.9 Future Plans

During the year we will continue to work with our staff side colleagues to support the management of security risks in the Trust. When a new structure is in place the security audit regime will be commenced

14.10 Assurance

Future audits and assessments will provide the Trust with assurance that standards of security are being maintained at a satisfactory level. Where there are gaps in standards of compliance, action plans have been formulated to address issues.

14.11 Managing Security Risks

Security risks in the Trust are managed in line with the processes used to manage all other risks this ensures that security risks are managed as part of the governance arrangements of each of the Clinical Business Units.

The Health Safety Security and Fire Team have maintained an overview of all security risks that are recorded on the risk register and will continue to challenge the management of security risks.

14.12 Security Incidents

During the period of 2018/19 the Trust had received 165 incidents and during the same period the following year the total was 144 and this is a reduction of 21.

Security Incidents by Sub-Category 2019/20														
Security by Sub-Category	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**	**%**
Loss/Theft - personal property	4	4	5	6	4	4	3	5	3	4	4	1	**47**	**32.6%**
Unsecured areas, doors, windows	1	3	2	1		3	1	2	1	2	1	1	**18**	**12.5%**
Intrusion/trespass	2		2	2		1	3	1	1			2	**14**	**9.7%**
Assistance calls	3	1	2	1			2		2	2	1		**14**	**9.7%**
Public disorder	1	1	3		1	2				1	1		**10**	**6.9%**
Unlawful use of controlled substances in hospital	4			2					1		2		**9**	**6.3%**
Keys lost / unaccounted for		1	1	1	2			1	1		1		**8**	**5.6%**
System failures			1	1	1	1	1	1	1				**7**	**4.9%**
Loss/Theft - trust property	1	2	1			2							**6**	**4.2%**
Criminal damage/vandalism to hospital property								1	1	1			**3**	**2.1%**
Lost SMART card/ID Badge				1			1					1	**3**	**2.1%**
Intruder alarm				1				1					**2**	**1.4%**
Damage to vehicle											1		**1**	**0.7%**
Lost and found property											1		**1**	**0.7%**
Loss/Theft - vehicle/bicycle/other		1											**1**	**0.7%**
Grand Total	**16**	**13**	**17**	**16**	**8**	**13**	**11**	**12**	**11**	**10**	**12**	**5**	**144**	**100.0%**

14.13 Loss / Theft – Personal Property

During the period protection of patient's property has been a priority area for action.

Action has been taken to ensure that:

- All ward areas have the correct documentation for recording property that patient's hand over to the Trust for safe keeping,
- Property is not kept in Controlled drugs cupboards on the wards
- Flowchart etc.
- Amnesty on property being stored on wards.

This risk will continue to be monitored and disclaimers regarding personal property are being installed around the Trust.

14.14 Violence and Aggression Incidents

Where the incident is related to malicious behaviour and a criminal breach the police are then involved and they asses if charges are appropriate. In August 2019 the health and safety team received several Incidents relating to one specific Patient who had been racially/religiously aggravated intentional harassment and causing distress to various staff. Following an Investigation by the health and Safety advisor the Trust took the decision to contact Merseyside Police. The Police then carried out their own investigation and concluded that these incidents are hate crimes. The Police then requested an interview with the Patient relating to various offences. On the 12th December 2019 the Patient was summonsed to appear at the Liverpool/Knowsley Magistrates Court and the case was adjourned to 9th January 2020 where he was found guilty of various serious offences and fined for each offence and also to pay court costs. Merseyside Police wrote to the Trust to thank them for bring this to their attention and the support the health and safety advisor had provided as part of the Police investigation, the case is now closed.

14.15 CCTV and Security Systems

The Trust uses a variety of security systems including the access to the Security Guard teams to assist with the provision of a pro-security culture amongst staff, professionals and the public – to engender a culture where the responsibility for security is accepted by all.

The systems used to protect patients, staff, professionals, property and assets are closed circuit TV, access control, intruder alarms, personal assistance alarm systems and mobile telephone systems.

The Health Safety Security and Fire Team use the CCTV to assist in the management and investigation of incidents on behalf of the Trust and any Police enquiries received.

14.16 External Warning Notices Received

The Trust receives external warnings of potential threats from a variety of organisations. The warnings are mostly for the protection of staff against violent individuals but can include threats such as organised theft or threats to damage property. These warnings can be received from NHS Protect, NHS England and the Police.

Between 01/04/2019 and 31/03/2020 the Trust had 5 NHS Protect Alerts 4 with the reason of Staff Safety and one with the reason Patient having Paranoid Schizophrenia. This resulted in risk assessments being reviewed, Medway checked and hard copies were up-dated in specific Departments.

14.17 Security Activity for 1st April 2019 to 31st March 2020

The Security management programme for the coming year will be included within the comprehensive forward plan 2020/21. Progress against the work plan will be reported to and monitored by the Health and Safety Committee and Audit Committee.

15.0 Fire Safety

The Health and Safety Department have maintained an overview of fire safety issues in the Trust over the last 12 months with limited resources.

The Trusts Fire Safety Policy RM04 was approved in December 2017 and is due for review in December 2020. The Policy sets out the Trusts commitment to ensure that all practical measures are taken to reduce the risks of fires occurring in Trust premises and will take all possible action to:

- Comply with the Fire Code Suite of documents.
- Provide and maintain a safe place of work.
- Provide and maintain a safe place to receive healthcare.
- Provide and maintain safe means of escape from premises.
- Provide and maintain adequate means of alerting staff in the event of fire.
- Provide and maintain adequate firefighting equipment.
- Provide adequate training to all members of staff.
- Take all possible action to prevent an outbreak of fire.
- Comply with all national requirements regarding fire safety.

The former Health and Safety Advisor left the Trust in July 2019, the Health and Safety Advisor had responsibility for monitoring the fire safety provisions for the Trust.

Therefore, since July 2019 the Trust has not had a dedicated member of staff to monitor the fire safety provisions for the Trust at both the Southport and Ormskirk sites. (as in accordance with the Regulatory Reform (Fire Safety) Order 2005 Article 11 – Fire Safety Arrangements).

On the 9th December 2019 Head of Health, Safety, Security and Fire placed a risk on the Risk Register highlighting the lack of a competent fire technical adviser.

The Regulatory Reform (Fire Safety) Order 2005 requires Enforcing authorities to carry out Fire Safety Audits of premises within their enforcement areas.

Merseyside Fire and Rescue Service is the enforcing authority for Southport and Formby District General Hospital, and Lancashire Fire and Rescue Service are the enforcing authorities for Ormskirk District General Hospital.

Ormskirk District General Hospital has not been inspected by Lancashire Fire and Rescue Service within the last 12months. (Note: I envisage that Ormskirk District General Hospital will be inspected within the next 12 months).

However, on the 19th March 2020 Merseyside Fire and Rescue Service inspected Southport and Formby District General Hospital and evaluated the fire safety provisions provided by the Trust. On the 26th March 2020, Merseyside Fire and Rescue Authority wrote to the Chief Executive of the Trust and confirmed that in their opinion the Trust has failed to comply with provisions of the Regulatory Reform (Fire Safety) Order 2005 because people were unsafe in case of fire, and served an Enforcement Notice on the Chief Executive of the Trust.

The Enforcement Notice (EN/MERS/466) highlighted 5 areas that required the Trust to address; these items included the following Articles and areas of deficiency:

- Article 9 – Risk Assessment: The sites fire risk assessments were not suitable and sufficient
- Article 8 (1) (a & b) – Duty to take general fire precautions: Breaches in compartment Breaches in compartment floors and walls may allow the spread of fire and smoke/ fire products from the place of origin to other areas of the premises.
- Article 13 (1) (a) – Fire-fighting and fire detection: Some areas are without automatic fire detection. This means that people may not be warned of a fire incident in time to escape safely.
- Article 21 (1 & 2) – Training: It is not clear from the site training records whether your staff have received raining that is appropriate.
- Article 15 (1) – Procedures for serious and imminent danger and for danger areas: A suitable emergency procedure is needed so that all relevant persons can be safely evacuated – the current strategy does not consider vertical movement of patients with spinal injuries.

The Enforcement Notice is currently due to expire on the 26th September 2020, a Fire Enforcement Report and Action Plan has been produced and submitted to the Health and Safety Committee and Merseyside Fire and Rescue Service for review.

15.1 Fire Risk Assessments

In accordance with the Regulatory Reform (Fire Safety) Order 2005 Article 9 (3) a programme of reviewing fire risk assessments had previously been in place each year. These reviews had been conducted on an annual basis by the Health, Safety, Security and Fire Team.

However, as Merseyside Fire and Rescue Service highlighted within their Enforcement Notice the Trusts Fire Risk Assessments have not been kept under regular review and lacked detail and as such have been deemed not suitable and sufficient.

It is worth noting, that since 2018 no Fire Risk Assessments have been undertaken or reviewed for the Ormskirk District General Hospital Site and as such their current fire risk assessments will also be deemed not suitable and sufficient when Lancashire Fire and Rescue Service undertake their next inspection.

Therefore, a programme to review and update the fire risk assessments at the Southport site to include more content and detail of the risks identified and the control measures implemented or needed has commenced.

15.2 Fire Evacuation Exercises

During the period 1st April 2019 to 31st March 20, the Health Safety Security and Fire Team have no record of any fire evacuation drills of non-patient areas of the Trust taking place.

The Regulatory reform (Fire Safety) Order 2005 Article 15 – Procedures for imminent danger and for danger areas. This Article requires the Trust to carry out evacuation drills, specifically in relation to fire. The Trust needs to be able to demonstrate that evidence is in place for procedures for serious and imminent danger and for danger areas, and that its procedures are being practiced (fire evacuation drills).

15.3 Fire Safety Training:

Fire Safety Training is delivered in accordance with the Fire Safety Policy RM04 and within Section 8 of the Policy training can be broken down into the following categories:

- Fire Safety Induction (once)
- Local Fire Safety Refresher Training (annually)
- General Fire Safety Training (Every 2 years)
- Fire Safety Training for Ward Managers & the Fire Response Team/s (Every 3 years).
- Fire Evacuation Technique (Every 2 years).

During the period 1st April 2019 to 31st March 20 the following training was delivered.

Training Title	Number of staff completed training	% Compliance	Positions that require competence
Fire Safety Induction	0	**N/K**	N/K
Local Fire Safety Refresher Training	2229	**76.44%**	2916
General Fire Safety Training	2568	**88.07%**	
Fire Safety Training for Ward Managers & Fire Response Team	19	**N/K**	N/K
Fire Evacuation Techniques	0	**N/K**	N/K
Key		**>=85%**	
		<80%	

Note: Since the COVID-19 pandemic practical fire safety training has been suspended until further notice.

15.4 Fire Safety Incidents

During the period 1st April 2019 - 31st March 2020, 47 fire safety related incidents were reported. (41 on the Southport site and 6 at the Ormskirk site). This represented an increase from the previous year of 6.8% when 44 fire safety incidents were reported.

Within the 12month reporting period there had been a significant increase in alarm activations by patients or public from 1 to 8 (700% increase) and malicious from 0 to 3 (300% increase).

Across the Trust all of the incidents reported from fire alarm activations resulted in no actual fires being recorded, an improvement from the previous year when 4 actual fires were recorded. This also resulted in a decrease in the number of unwanted fire signals from 7 to 5.

HTM 05-01 ‘Managing healthcare fire safety’ sets out specific responsibilities in respect of fire safety, including minimisation of false alarms. The Trust has a responsibility to minimise false alarms, and it’s incumbent on all staff to reduce false alarms whenever possible, by controlling their environment, processes and actions to avoid unnecessary activations of the fire detection and alarm systems.

Fire safety training should be developed to incorporate causes of false alarms, means of minimising their occurrence, and actions to be taken to avoid unnecessary disruption. Further training should be provided in incident recording, reporting and remediation action.

HTM 05-03 Part H Reducing false alarms in healthcare premises defines causes of fire detection and alarm activations as one of two incident types: fires or false alarm.

- Fire – a fire can be regarded as an incident resulting in the uncontrolled emission of heat and/or smoke.
- False alarm – activation of the fire detection and alarm system resulting from a cause other than fire.
- A false alarm becomes an unwanted fire signal at the point the fire and rescue service is requested to attend.

Annual Report: 01/04/2018 – 31/03/2019			Annual Report: 01/04/2019 – 31/03/2020		
Site	**False Alarm Category**	**Number**	**False Alarm Category**	**Number**	**% Increase + or Decrease - on previous year**
SFDGH	Accidental damage	2	Accidental damage	2	**0%**
	Activated by patient or public	1	Activated by patient or public	8	**700%**
	Environmental effect – cooking fumes	4	Environmental effect – cooking fumes	6	**50%**
	Environmental effect – other	7	Environmental effect – other	10	**43%**
	Environmental effect - smoking	5	Environmental effect - smoking	1	**80%**
	Good intent	1	Good intent	1	**0%**
	Malicious	0	Malicious	3	**300%**
	Management procedures not complied with	3	Management procedures not complied with	1	**67%**
	Systems fault – design	3	Systems fault – design	4	**33%**
	Unknown	8	Unknown	5	
	Total	**34**	**Total**	**41**	**20.6%**
	Actual Fires	**Number**	**Actual Fires**	**Number**	
	Malicious	**1**		**0**	
	Total	**1**	**Total**	**0**	**100%**
S'PORT & FORMBY COM'TY	Left blank (*unknown*)	**2**	**0**	**0**	**100%**
	Total	**2**	**Total**	**0**	**100%**
ODGH	Environmental effect other	2	Environmental effect other	2	**0%**
	Unknown	1	Unknown	2	**100%**
	System Fault Design	1	Alarm activated by patient or public	2	**100%**
	Total	**4**	**Total**	**6**	**50%**
	Actual Fires	**Number**	**Actual Fires**	**Number**	
	Equipment failure electrical	2		0	**100%**
	Wire & cable fixed	1		0	**100%**
	Total	**3**	**Total**	**0**	**100%**
	Trust Total	**44**	**Trust Total**	**47**	**6.8%**

15.5 Future Plans

The main fire safety priority for the Health, Safety, Security and Fire Team over the next 12 months is to ensure compliance with the requirements of the Enforcement Notice within the agreed timeframes specified by the Enforcing Authority.

To achieve compliance with the Enforcement Notice the Trust will need to embed a robust fire safety

management structure, systems and culture across the Trust sites and ensure that the Trusts fire safety provisions are monitored and maintained during future Fire Safety Audits to prevent reoccurrence.

Additional control measures will include:

- Review of the Trusts Fire Safety Policy RM04
- Publication of the Trusts Fire Safety Strategy Document
- Conduct a review of the current Fire Safety Training packages to ensure that they are suitable and sufficient for the role and responsibilities of individuals across the Trust.
- Conduct external site visits to Trust premises to ensure statutory compliance with the Regulatory Reform (Fire Safety) Order 2005.
- Complete the regular review of Trust wide Fire Safety Risk Assessments.

HEALTH AND SAFETY TEAM FORWARD PLAN 2020/2021

KEY PRIORITIES

	Aim/ Target /Objective	How this will be Achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where this will be reported/monitored to i.e. Committee/ Group
1	Undertake a health, safety, security and fire (H,S,S &F) audit of all Wards and clinical area	Health and Safety team producing a schedule of dates to undertake the audit	A completed audit of all wards and clinical areas produced highlighting recommendations and actions identified	Copy of the audit report highlighting any recommendations and actions are being addressed	Health and Safety Team	H&S Sub-Committee meeting
2	Undertake a (H,S,S &F) audit of all non- clinical areas including office storage areas etc.	Health and Safety team producing a schedule of dates to undertake the audit	A completed audit of all wards and clinical areas produced highlighting recommendations and actions identified	Copy of the audit report highlighting any recommendations and actions are being addressed	Health and Safety Team	H&S Sub-Committee meeting
3	Source a Health and Safety Management system which will provide various Health and Safety templates etc	The Health and Safety Manager to contact various external Safety Management System providers and obtain a demonstration of their Health and Safety System	The Trust will have purchased a System that meets the legal requirements of a Health and Safety Management System	All Wards and Departments will be utilising a uniformed system which will provide standardised documentation throughout the Trust	Health and Safety Team	H&S Sub-Committee meeting
4	Monthly meeting arranged with Assistant Director of Quality to monitor CQC Regulations for Quality and Safety (Regulation 17)	By scheduling monthly meetings with the Assistant Director of Quality	To highlight any gaps within the CQC Regulations and an action plan produced	Documentation will be provided as evidence of compliance with various sections of the regulation	Health and Safety Team	H&S Sub-Committee meeting

	Aim/ Target /Objective	How this will be Achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where this will be reported/monitored to i.e. Committee/ Group
5	Review (H,S,S &F) policies to ensure the Trust meets statutory requirements and to take into account any changes to Trust process	Reviewing the schedule of all policies highlighting the review dates for reviewing and updating were necessary	The policy schedule is reviewed and updated three months prior the review date to ensure all policies on the policy library are in date and current	Policies on Intranet for staff to review and obtain	Health and Safety Team	H&S Sub-Committee meeting
6	Provide bespoke training packages to include: ➢ Risk Assessment ➢ COSHH Assessments ➢ Health and Safety for Managers	Health and Safety team to produce these bespoke packages	All relevant and nominated staff will of received the training	Staff attendance records	Health and Safety Team	H&S Sub-Committee meeting
7	To improve and support awareness of H&S	To provide H&S risk assessors drop in sessions	Risk Assessors knowledge will be increased and enhanced	Specific documentation e.g. risk assessments	Health and Safety Team	H&S Sub-Committee meeting
8	Undertake a full review and update of the Trust Health, safety, security and fire training provision including Induction and mandatory training	Reviewing current training packages to ensure it meets current legislation provision	All Trust training packages will have been amended to meet current changes in health and safety legislation	Copies of the revised training packages will be available	Health and Safety Team	H&S Sub-Committee meeting
9	Visit all external satellite premises to undertake a joint (H,S,S &F) inspection	Contact the various managers with responsibility for satellite premises and arrange a site visit	All staff within the various satellite premises will have awareness of their Health and Safety responsibilities and be aware of any	Copies of the joint (H,S,S &F) report and action plan	Health and Safety Team	H&S Sub-Committee meeting

	Aim/ Target /Objective	How this will be Achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where this will be reported/monitored to i.e. Committee/ Group
			shortfalls within Health and Safety provision			
10	Central Alerting System (CAS) relating to Estates and Facilities alerts to be addressed	Nominate an Estates and Facilities lead to addresses the EFA's and EFN's	The nominated lead will produce an action plan to reflect the actions highlighted within the specific alert	Copy of the completed action plan highlighting actions have been addressed and closed as complete	Health and Safety Team and Estates and Facilities	H&S Sub-Committee meeting
11	Review all Estates and Facilities projects to establish if an Asbestos Survey is required	Once the documentation has been reviewed the Health and Safety Manager will establish if an Asbestos Survey is required	If an Asbestos Survey required arrange for the Survey to be undertaken	A copy of the completed Survey which will highlight if Asbestos is present	Health and Safety Team and Estates and Facilities	H&S Sub-Committee meeting
12	If Asbestos has been identified within the Asbestos Survey then abatement maybe required	Arrange for an abatement contractor to visit site to discuss the various options of abatement or encapsulation of the material	If an Asbestos Survey required arrange for the Survey to be undertaken	A copy of the completed Survey which will highlight if Asbestos is present	Health and Safety Team and Estates and Facilities	H&S Sub-Committee meeting
13	Undertake joint Health and Safety Inspections with Trade Union Health and Safety Representatives	Schedule dates and times with Trade Unions to undertake theses inspections	Joint inspections will be undertaken in agreed areas	Copies of the joint inspection and action plan	Health and Safety Team and Trade Union Health and Safety Representatives	H&S Sub-Committee meeting

	Aim/ Target /Objective	How this will be Achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where this will be reported/monitored to i.e. Committee/ Group
14	Undertake the following Risk Assessments in all areas ➢ Workplace Risk Assessment ➢ Local Fire Risk Assessments ➢ COSHH Assessments	Appoint a Risk Assessor to lead on all Risk Assessments and provide appropriate training	Risk Assessments will have been undertaken in all areas	Each Ward/Department will have individual Risk Assessments highlighting all the risks and hazards associated within their areas	Health and Safety Team	H&S Sub-Committee meeting
15	Review current Risk Assessments and identify any gaps within CBU's	Work with CBU Managers and provide support in any gaps in Risk Assessments	All CBU will have reviewed and updated Risk Assessments	Copies of all Risk Assessments will be available for all staff to view	Health and Safety Team	H&S Sub-Committee meeting
16	Produce Quarterly Incident Reports relating to ➢ Health and Safety ➢ Fire ➢ Security	Obtaining statistical data from the DATIX System to produce these reports	Report highlighting the various statistical information within each CBU	Copies of the report will be produced and disseminated to stakeholders	Health and Safety Team	H&S Sub-Committee meeting
17	Produce a report and action plan for all RIDDOR reportable incidents	The Health and Safety Team will undertake a comprehensive investigation	The Health and Safety report and action plan will highlight any recommendations and actions to prevent a potential reoccurrence	Copies of the report will be produced and disseminated to stakeholders	Health and Safety Team	H&S Sub-Committee meeting

	Aim/ Target /Objective	How this will be Achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where this will be reported/monitored to i.e. Committee/ Group
18	Due to the Coronavirus outbreak the Health and Safety Team will be following HM Government Guidance on future outbreaks	The Health and Safety Team will be reviewing and monitoring the various updates and advice	Any updates and advice published will be acted upon by the Health and Safety Team relating to Workplace environment and staff health and wellbeing	Copies of any documented Risk Assessments or advice provided to the Trust	Health and Safety Team and Occupational Health/HR Department	H&S Sub-Committee meeting and Health and Wellbeing Group

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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 September 2020**
Agenda Item	**TB137/20**	**FOI Exempt**	**No**
Report Title	Sefton Special Educational Needs and Disabilities (SEND)		
Executive Lead	Trish Armstrong-Child - Chief Executive		
Lead Officer	Therese Patten - Deputy CEO and Director of Strategy		
Action Required	☐ **To Approve** ☐ **To Assure**	**X To Note** ☐ **To Receive**	

Purpose

To inform the Board about the position in Sefton with regards to SEND services and to ensure members are sighted on essential documents developed to address the situation.

Executive Summary

In December 2016 Ofsted and the Care Quality Commission issued a Written Statement of Action (WSOA) to Sefton local authority and the clinical commissioning group as significant areas of weakness were found on inspection within Sefton Special Educational Needs and Disabilities (SEND) services. Her Majesty's Chief Inspector determined that both parties were jointly responsible for submitting a written statement to Ofsted. Between 15 and 17 April 2019, Ofsted and the Care Quality Commission revisited Sefton to decide whether the local area has made progress, however inspectors were of the opinion that local area leaders had not made sufficient progress to improve each of the serious weaknesses identified at the initial inspection.

The situation was taken extremely seriously by Sefton Council and health partners with immediate and extensive action being taken. A new strategy and plan were presented to Sefton Health and Wellbeing Board during 2019 and approved at Cabinet January 2020. A revised governance structure has also been implemented with all partners assuring full co-operation. All partner Boards have been challenged to be sighted on the Sefton Early Help Strategy and the Children and Young People's Plan in the context of both their own provision and within wider partnership working arrangements. A return visit is expected soon to review progress.

The documents attached are:

1. Sefton Early Help Strategy for Children, Young People and Families 2020-2025

The Early Help Strategy sets out the overall strategic approach across the partnership and the principles all partners should all be working too. The integrated strategy is central to delivering the shared ambition that all children, young people and families in Sefton will be safe, healthy and happy, and will aspire to be the best they can be. Effective early help requires a whole family approach and impacts all stakeholders working with children and families. The revised strategy acknowledges that agencies will be addressing their own distinct needs and meeting a range of key performance indicators against a variety of policy drivers and aims to provide an umbrella framework of key principles that can be applied across all agendas.

2. Sefton Children and Young People's Plan 2020-2025

The My Sefton: heard, happy, healthy, achieving plan for all children, young people and their families that sets out how partners will maximize the health and wellbeing of all the children and young people living in Sefton. Sefton Council and the Sefton Clinical Commissioning Groups have agreed a series of priorities for future services and support. These priorities are based on what children, young people, their families and their Carers have said about their experiences and care. The document is a single strategic and overarching plan for all services which affect children and young people across Sefton. It

Southport and Ormskirk Hospital NHS Trust

sets out how the Council, with its strategic partners, will achieve improvements. The Health and Wellbeing Board (incorporating the Children's Trust) sets out an overarching vision through the Health and Wellbeing Strategy and oversees the delivery of the Children and Young Peoples Plan. It gives overarching Governance and Accountability with membership from across Health, Social Care, the third sector and plans to include Police and Housing.
Recommendation
The Board is asked to note the Strategy and Plan and to receive progress updates on how the Trust is working in partnership to deliver the SEND agenda.
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:**
Therese Patten	Therese Patten

Sefton Council

Sefton Integrated Early Help Strategy for Children, Young People and Families

2020 - 2025

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Foreword and Introduction

We are delighted to introduce the revised Early Help strategy for Sefton.

This integrated strategy is central to delivering our shared ambition that all children, young people and families in Sefton will be safe, healthy and happy, and will aspire to be the best they can be. It has been co-produced with partners, as we recognise that early help is a collaborative approach, not just an isolated service provision.

The strategy is just the beginning. We realise this strategy cannot be achieved by a single organisation. Working together is important in times of challenge, austerity has seen significant cuts in the money going to public services so there is a need to work differently and achieve better with less. In line with the newly refreshed Children and Young People's Plan we will ensure children are heard, happy, healthy and achieve. We understand that it is our collective responsibility to ensure we can create the right conditions for children, young people and families to thrive in Sefton. We will need to continue to work with partners to embed the strategy, develop skills and knowledge across the workforce, to ensure practitioners are confident with the approach.

We understand that for many children, young people and families problems may emerge. Early help is provided to prevent or reduce the need for statutory or specialist interventions wherever possible. Early help seeks to meet the need, resolve the problem and prevent it becoming entrenched.

As we refresh the strategy, we celebrate the work that has already been done and look forward to the next stage of early help and how much we can achieve together to support children, young people and families across Sefton

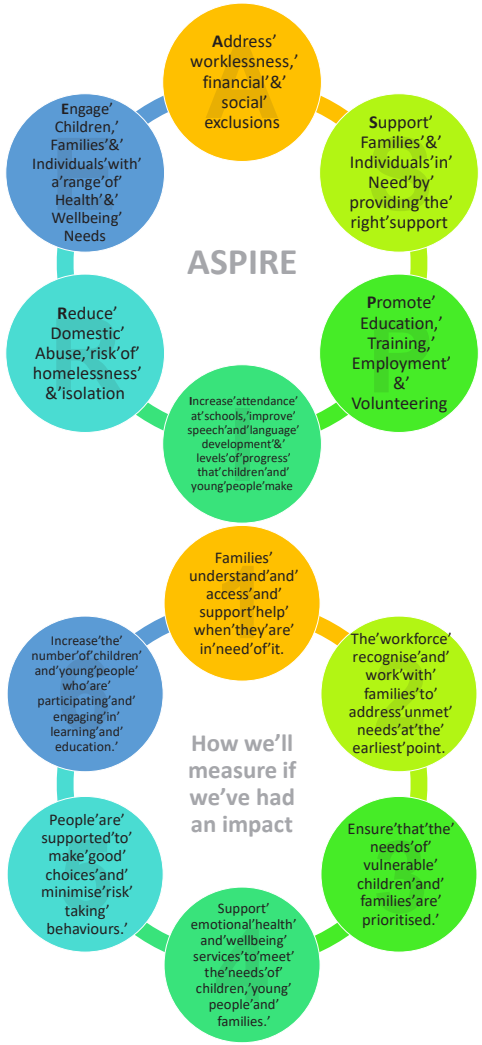
Councillor John Joseph Kelly
Cabinet Member

Vicky Buchanan
Interim Director of Children's Social Care and Education

Our Behaviour

- Support Inspiration
- Tailor support to the needs of the individual child, young person & family
- Support children, young people & families
- Constructively challenge when needed
- Support each other
- Ensure there is sufficient learning & development for the frontline workforce young person and family
- Take responsibility
- Create opportunities for success

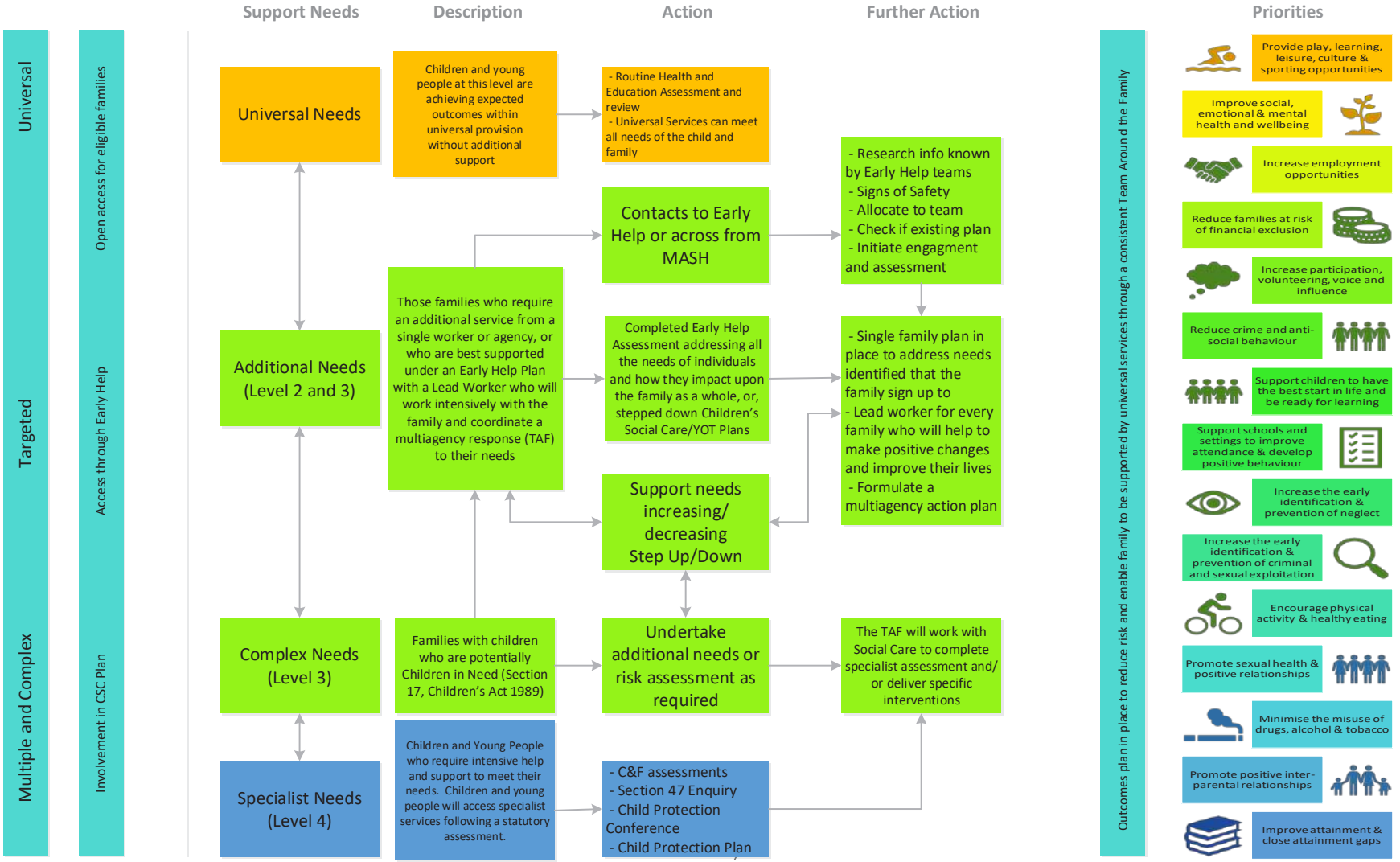
Our Model



Our Passion

- Families understand & access help & support when they are in need of it. (uptake of early help offer, increase in EH assessments, referrals, reduction in inappropriate referrals to CSC, decrease in stepping up)
- The workforce recognise & work with families to address unmet needs at the earliest point (Timeliness of referrals, length of time on a plan, timeliness of referral to assessment 'drift')
- Ensure that the needs of vulnerable children & families are prioritised. (Allocation timeliness, categorising of need, SEND EHC plans, 2 Year old offer, Appropriateness of lead practitioners)
- Support emotional health & wellbeing services to meet the needs of children, young people & families. (Health indicators, Commissioning, A&E attendances)
- People are supported to make good choices and minimise risk taking behaviours. (Young Offenders, Exploitation, A&E attendances, Bullying)

Sefton Early Help Strategy


Support Needs
Description
Action
Further Action
Priorities
Universal
Targeted
Multiple and Complex
Open access for eligible families
Access through Early Help
Involvement in CSC Plan
Universal Needs
Children and young people at this level are achieving expected outcomes within universal provision without additional support
- Routine Health and Education Assessment and review
- Universal Services can meet all needs of the child and family
Additional Needs (Level 2 and 3)
Those families who require an additional service from a single worker or agency, or who are best supported under an Early Help Plan with a Lead Worker who will work intensively with the family and coordinate a multiagency response (TAF) to their needs
Contacts to Early Help or across from MASH
- Research info known by Early Help teams
- Signs of Safety
- Allocate to team
- Check if existing plan
- Initiate engagment and assessment
Completed Early Help Assessment addressing all the needs of individuals and how they impact upon the family as a whole, or, stepped down Children's Social Care/YOT Plans
- Single family plan in place to address needs identified that the family sign up to
- Lead worker for every family who will help to make positive changes and improve their lives
- Formulate a multiagency action plan
Support needs increasing/ decreasing Step Up/Down
Complex Needs (Level 3)
Families with children who are potentially Children in Need (Section 17, Children's Act 1989)
Undertake additional needs or risk assessment as required
The TAF will work with Social Care to complete specialist assessment and/ or deliver specific interventions
Specialist Needs (Level 4)
Children and Young People who require intensive help and support to meet their needs. Children and young people will access specialist services following a statutory assessment.
- C&F assessments
- Section 47 Enquiry
- Child Protection Conference
- Child Protection Plan
Outcomes plan in place to reduce risk and enable family to be supported by universal services through a consistent Team Around the Family
Provide play, learning, leisure, culture & sporting opportunities
Improve social, emotional & mental health and wellbeing
Increase employment opportunities
Reduce families at risk of financial exclusion
Increase participation, volunteering, voice and influence
Reduce crime and anti-social behaviour
Support children to have the best start in life and be ready for learning
Support schools and settings to improve attendance & develop positive behaviour
Increase the early identification & prevention of neglect
Increase the early identification & prevention of criminal and sexual exploitation
Encourage physical activity & healthy eating
Promote sexual health & positive relationships
Minimise the misuse of drugs, alcohol & tobacco
Promote positive inter-parental relationships
Improve attainment & close attainment gaps

Preface

In July 2018, the Government published revised statutory guidance; 'Working Together to Safeguard Children: guidance to inter-agency working' to safeguard and promote the welfare of children. This sets out the legal requirements that health professionals, social workers, police, education professionals and others working with children must follow. The guidance emphasises that effective support and safeguarding for children and young people is the responsibility of all professionals working with children and young people and provides advice in support to sections 10 and 11 of the Children Act 2014, where the primary duties for all agencies are set out.

Scope of the strategy

Effective early help requires a whole family approach and encompasses all stakeholders working with children and families. This includes Health, Police, Education, Children's Social Care, Local Authority Early Help, Voluntary Community and Faith organisations and the wider public.

The revised strategy acknowledges that agencies will be addressing their own distinct needs and meeting a range of key performance indicators against a variety of policy drivers and aims to provide an umbrella framework of key principles that can be applied across all agendas.

Working Together to Safeguard Children, 2018

'Effective early help relies upon local organisations and agencies working together to: identify children and families who would benefit from early help; undertake an assessment of the need for early help; provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to improve the outcomes for the child'

Engagement with the strategy by all sectors will require some cultural and operational changes but by doing so, and actively working together to deliver outcomes, we believe that we will positively change the relationship between the community and the public sector in ways which build and strengthen community resilience.

We are still at the beginning of this journey and the strategy is aspirational, but we are building on solid foundations established through the success of existing early intervention work.

Introduction

Early help and early intervention mean taking action to support a child, young person or their family early on when a problem emerges. It can be required at any stage in a child's life from pre-birth through to adulthood and applies to any problem or need that the family cannot deal with or meet on their own.

We know from what children and their families tell us that it can be daunting asking for help. Families have told us that they don't want to have to tell their story more than once to lots of different people. This strategy will help us to make every contact count.

The Strategy supports 'right help, from the right person at the right time' principles being adopted across Sefton which will help ensure a cohesive early help offer. The strategy will be delivered by all partners collectively with a commitment to:

- Working better together in an open, honest partnership approach with consent of the child and their family
- Identifying strengths and needs and working together to find practical and achievable solutions
- Providing the right information and advice to enable children and their families to make positive changes themselves with support tailored to their needs
- Help children and their families to build protective factors and family resilience to prevent situations recurring.

What is it like for Children and Young People living in Sefton?

The number of children and young people living in Sefton (0-25 year olds) is 62,100 a fall of 14% (9,990) since 2001.

Sefton is a good place for children and young people to live and grow up. Most receive their immunisations, with rates being close to - or above - the national average.

On the whole our children and young people achieve in school. However, there are still some that do not reach their full potential which impacts on their ability to go into further education, training and to get a job.

The health of children and young people is generally improving and they have access to a wide range of physical activity opportunities.

Almost 20% of our children are obese when they leave primary school at 11 years.

The number of hospital admissions related to alcohol use in under 18's is also higher (though declining) than the England average and childhood smoking rates are average.

There are fewer teenage mothers in the borough than in previous years. Whilst the total number of births in Sefton is not rising, there has been an increase in the number of babies born to non-British born women. These mothers may need additional support to access maternity and other health services.

Sefton mothers are more likely to smoke during pregnancy and less likely to breastfeed their baby at 6 weeks.

Some of our children and young people cannot live with their parents or families; they live with Foster Carers, in children's homes or are adopted. These children and young people are more likely to experience poor life chances

As of November 2019 there are 550 Looked After Children

If Sefton had 100 children (0-18 years inc.)

As they grown up:

- 19 will live in poverty
- 6 will be low birth weight babies (below (2.5kg)
- 66 will be achieving good development in Early Years Foundation Stage One
- 76 will achieved year 1 phonics
- 93 will make expected progress in primary school in Reading
- 94 will make expected progress in primary school in Writing
- 93 will make expected progress in primary school in Maths
- 58 will achieve A*-C GCSEs including Maths and English
- 25 will be overweight/obese in reception
- 35 will be overweight/obese by year 6
- 16 will be eligible for free school meals
- 5 will be persistently absent from school
- 13 will live with lone parent families

If Sefton's constituencies had 100 children (0-18 years inclusive)

As they grown up:

	Southport	Central	Bootle
Will live in poverty	15	9	29
Will be low birth weight babies (below (2.5kg)	7	6	8
Will make expected progress in primary school	93	96	92
Will achieve A*-C GCSEs including Maths and English	58	58	52
Will be overweight/obese in reception	22	23	28
Will be overweight/obese by year 6	36	31	39
Will be eligible for free school meals	13	13	28
Will be persistently absent from school	8	7	9
Will live with lone parent families	19	15	31

Detailed analysis of our families and their communities can be found in:

- Joint Strategic Needs Assessment **https://www.sefton.gov.uk/your-council/plans-policies/business-intelligence,-insight,-performance/joint-strategic-needs-assessment-(jsna).aspx**

Vision

Our ambition is that **all children, young people and families in Sefton will be safe, healthy and happy, and will aspire to be the best they can be.**

In Sefton, we believe that every child should have the opportunity to reach their full potential. We believe that children should grow and achieve within their own families and communities, when it is in their best interests and it is safe for them to do so. By working together, we will develop flexible services which are responsive to children and families' needs.

Sefton is establishing a vision for the future that will provide:

- A system wide approach, with joint, pooled resources and integrated pathways operating across organisational boundaries
- An outcome focussed, system wide approach delivering long term sustainable solutions for individuals and families that enables (to secure) resilience and independence
- A shift from acute provision to an increase in prevention and early help activity
- Evidence based early help interventions that are built around customer need
- Locality based delivery with a trauma informed workforce

Early help is everyone's responsibility; we want children, families, communities and agencies to work together so that families are assisted to help themselves and are supported as soon as a need arises, thereby improving their wellbeing and life chances.

Early help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. If early help is not offered, there is a very real risk that for some children, their social and emotional development will be irrevocably impaired, they will experience significant harm, or their family life will break down.

Although research shows that the most impact can be made during a child's early years, and in particular their first 1001 critical days, early help is not just for very young children, as problems may arise at any point throughout childhood and adolescence. Early help in pregnancy and supporting parents to be good parents is also important. Early help includes targeted services designed to reduce needs or prevent specific problems from becoming entrenched, and there is substantial evidence that early help can make a difference in improving outcomes.

As a partnership, we will:

- Understand those families where children may be at risk of not reaching their full potential and share concerns
- Build a relationship with the family as early as possible, and work with them to create a family environment that provides children with the best life chances and prevent problems from arising or escalating
- Reduce the number of children and their families requiring support from specialist services.

Sefton's Integrated Early Help Strategy has been developed across the partnership and will align with Sefton's vision for the new operating model. This will enable us to provide a joined up, effective early help offer for children aged 0 to 19 years (up to 25 for children with disabilities) and their families. Support services will be provided at a locality level, will be evidence-based and delivered through a shared partnership approach to delivering universal and early help services.

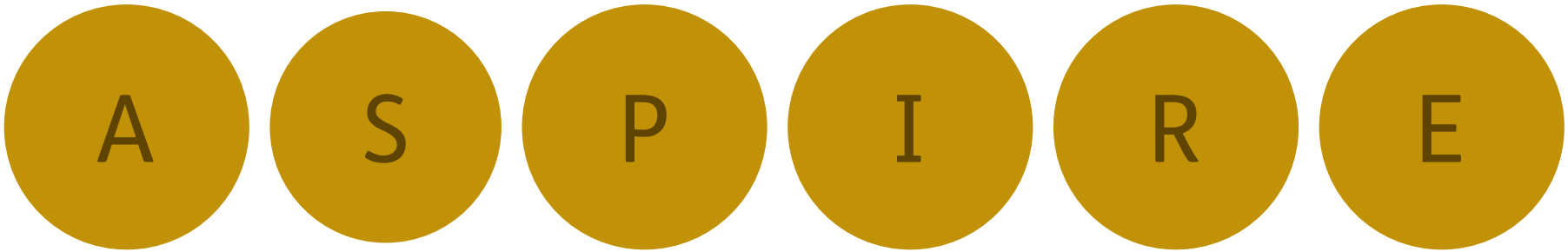
Early Help Outcomes across the Partnership

Sefton's Turnaround Programme has been mainstreamed and there is a detailed multi-agency plan in place; the Service Transformation Maturity Plan. This plan will be monitored through the Sefton Early Help Partnership Group and updated regularly. There is strong commitment across the partnership, at all levels, to delivering change which improves the outcomes and experience for children and their families. This maturity model will be used to measure the impact and success of early help alongside **ASPIRE** - the Locality Outcomes Framework.

ASPIRE includes:

Sefton are committed to delivering an effective all age partnership early help offer and a more effective whole family systemic locality-based approach to early help.

Through ASPIRE early help priorities have been identified to support the reduction in demand, and impact, upon statutory services by preventing escalation, where safe to do so, to statutory and specialist services. We also focus on families coming to early help from statutory and specialist services, bringing them down the continuum of need and helping them to access, and remain accessing, universal services.



Addressing Worklessness, financial and social exclusions

Supporting Families and Individuals in Need by providing the right support

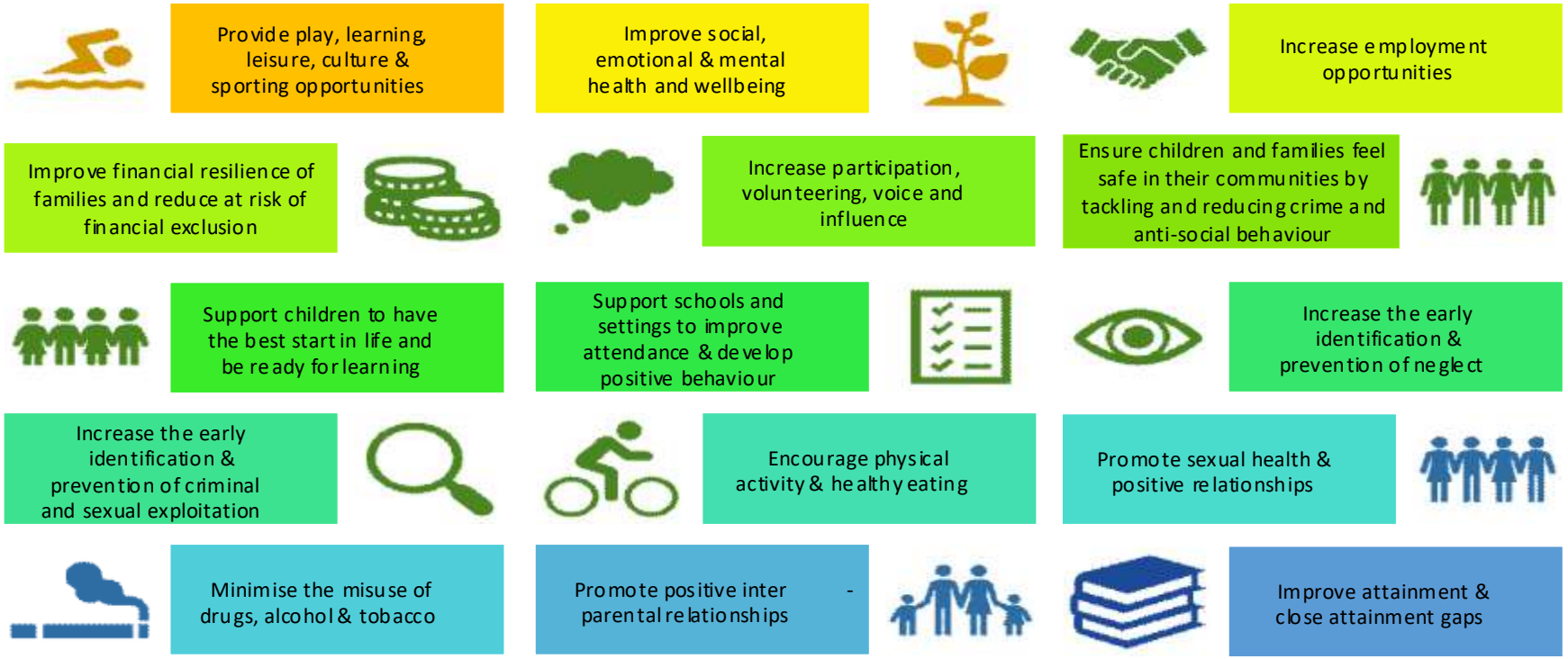
Promoting Education, Training, Employment and Volunteering

Increasing Attendance at schools, improve speech and language development and levels of progress that children and young people make

Reducing Domestic Abuse, risk of homelessness and isolation

Engaging Children, Families and Individuals with a range of Health and Wellbeing Needs

Our key priorities include:



Guiding Principles for the Early Help Partnership

Problems may emerge at any point through childhood and adolescence. Early help is provided to prevent or reduce the need for statutory or specialist interventions wherever possible. Early help seeks to meet the need, resolve the problem and prevent it becoming entrenched.

Within this context our early help approach is based on a set of shared principles:

1. **Early help is everyone's responsibility.** All children and young people should have the opportunity to reach their full potential. Parents have the primary responsibility to meet the needs of their children and ensure the wellbeing and prosperity of their family. We recognise that parenting can be challenging and asking for help should be seen as a sign of responsibility rather than a parenting 'failure'. It is essential that when support is required, we all act to provide the right help, from the right worker, at the right time, to improve children's life chances.

2. **Wherever possible all children and families' needs will be met by universal services.** Universal services working with children and adults have a role to ensure families are achieving positive outcomes, to be aware of potential difficulties and act early to prevent needs escalating. Universal services must remain involved even if a child is receiving additional or specialist support to ensure there is a joined up, whole system response to meeting needs.

3. **Listen to children and families and treat them as partners.** In most cases it should be the decision of the parents when to ask for help or advice, although there are occasions when practitioners may need to engage parents actively, and with their consent, help them to prevent problems becoming more serious. All services must keep the child at the centre of the solution, encourage families to harness their own resourcefulness and build supportive community networks, thereby enabling families to develop resilience.

4. **Focus on whole Family working.** Sefton is committed to a culture shift in the way that we engage and work with families. In particular, adopting a 'whole family approach' and strongly encouraging multi- agency working. This requires a workforce development strategy that underpins all work with children and families across thresholds. The principles of 'whole family working', 'sustained outcomes' and building 'progression' into the way that we work with families will help to ensure that education, employment and training are a key feature in families' action plans.

5. **All services will work together with children and families to promote family strengths, build resilience and independence.** This includes effective information sharing and joint working between professionals in children's and adult's services to reduce the impact that adult's problems have on children's experiences.

6. **Understanding needs.** We can best understand the needs of children and families within their communities and maximise our multi-agency resources using evidence-based approaches, learning from feedback and listening to the voice of the child and family. With robust performance management in place we will be able to evidence positive, sustainable impact and best value.

7. **Ensure clear pathways to support**. We want all families to have easy access to support when it is needed. We will set out clearly what support is available and make it easy for families to contact services themselves.

8. **Everyone will encourage integrated working.** This includes anyone who works with children and families, part or all of the time; whether employed, self-employed or in a voluntary capacity. If you are a nurse, volunteer, teacher, early help worker, sports coach, social worker or any other member of the children's workforce, integrated working and building strong working relationships concerns you. We want the services supporting children and families to work much more closely together, forging lasting and meaningful relationships that improve the lives of the children of Sefton in the short, medium and long term.

OfSTED, Early Help: Whose Responsibility? 2015

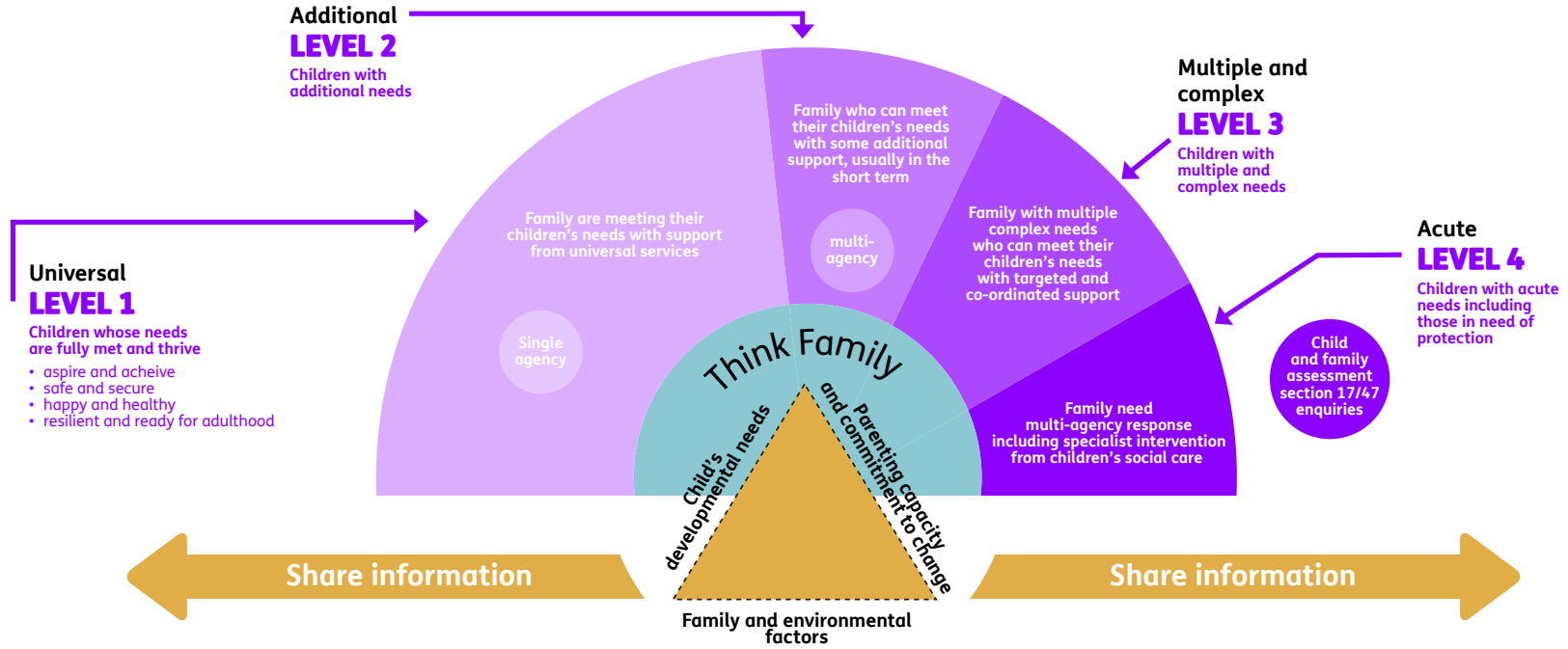
'Local authorities and partner agencies delivering early help to children and families should improve the quality and consistency of assessment and plans by ensuring plans are regularly reviewed and that these reviews evaluate the child's and family's progress'

Our Early Help Approach

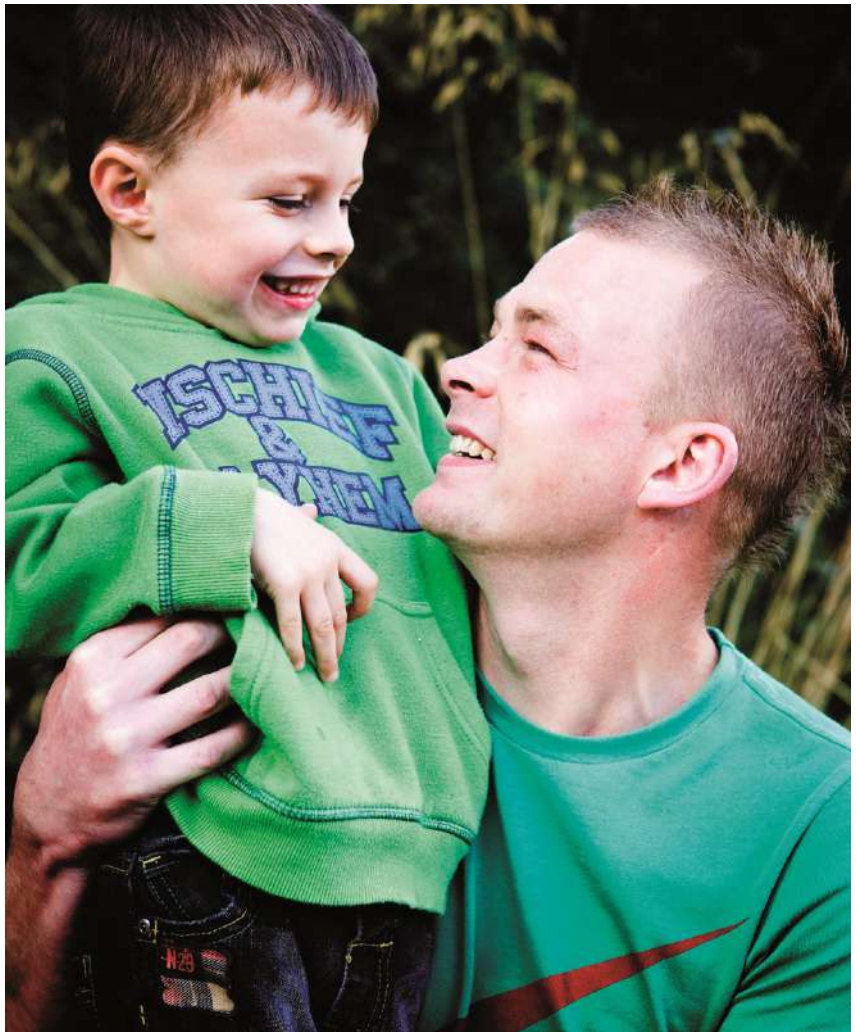
Effective support through the 'right help, from the right worker, at the right time' principles will improve the relationship between the four levels of need; **Universal, Additional, Multiple and Complex and Acute need.**

Since 2014 we have successfully used a 'threshold of need' model to correctly identify the level of need and proportionate support needed. The Level of Need document published in October 2017 is fully implemented across the partnership; this document is however currently under review.

'Where a child and family would benefit from co-ordinated support from more than one organisation or agency there should be an inter-agency assessment. These early help assessments should be evidence-based, be clear about the action to be taken and services to be provided and identify what help the child and family require to prevent needs escalating to a point where intervention would be needed through a statutory assessment...'



Assessment and planning for children and families in Sefton



Identifying needs at an early stage using the Early Help Assessment gives agencies working with children, young people and their families a common tool to understand the needs of the child or young person and their family. It is only once the full needs are identified that the appropriate support can then be put in place. It is an expectation that where the needs of a family have been identified for additional support, an Early Help Assessment for the whole family will be completed, in partnership with the family.

Working Together to Safeguard Children 2018 makes it clear that safeguarding children and families and promoting their welfare is the responsibility of all practitioners working with children and young people, and that practitioners should understand the criteria for taking action across a continuum of need, including Early Help.

Effective early help relies upon local organisations and agencies working together to:

- identify children and families who would benefit from early help
- undertake an assessment of the need for early help
- provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to improve the outcomes for the child

Early help assessments should be evidence-based and co-produced with families, be clear about the action to be taken, and services to be provided, and focuses on improving outcomes.

Within the assessment it is important to highlight the strengths and resources within the family. This is a useful focus when agreeing the action plan and helping other agencies to understand the protective factors within the family and identify

how they can facilitate change. The more strengths present, the lower the risk will be and as support progresses it would be expected that risk factors decrease, and strengths increase.

It is not expected that practitioners will be experts in all areas of the assessment. During the assessment stage the Team Around the Family (TAF) can begin to be established. The practitioner completing the assessment will act as the lead until their role in supporting the family comes to an end. The Lead Worker can call upon their colleagues supporting the family to assist in the assessment process. This ensures that the intervention is proportionate, appropriate, timely and effective.

The Early Help Family Assessment is designed to help families to develop self-help and self-management skills in order to better meet their long term needs and to reduce their reliance on public services.

If the outcome of this assessment is single agency, the work will be completed by a lead worker. If however, the outcome identifies multifaceted problems and need for more than one agency, then a multi-agency action plan should be put in place through the assess-plan-review process.

An ongoing programme of training will be available for all practitioners regarding the assess-plan-review process and associated tools. Partners will be encouraged to complete assessments, which will be quality assured to maintain a high standard.

Other assessment tools are available to complement Early Help Family Assessment. The Outcome Star tools are a suite of assessment tools that can be helpful in evaluating, areas of, need and strength and supporting families.

For instances where neglect has been identified as the primary factor, the Graded Care Profile 2 should be completed with the contribution of practitioners involved and used as the ongoing assessment tool to measure outcomes.

Sefton's Assess-Plan-Review guidance for practitioners; provides them with a guide of how to deliver effective early help support and explains the criteria for providing help to children, young people and their families.

Sefton Council's Locality Model

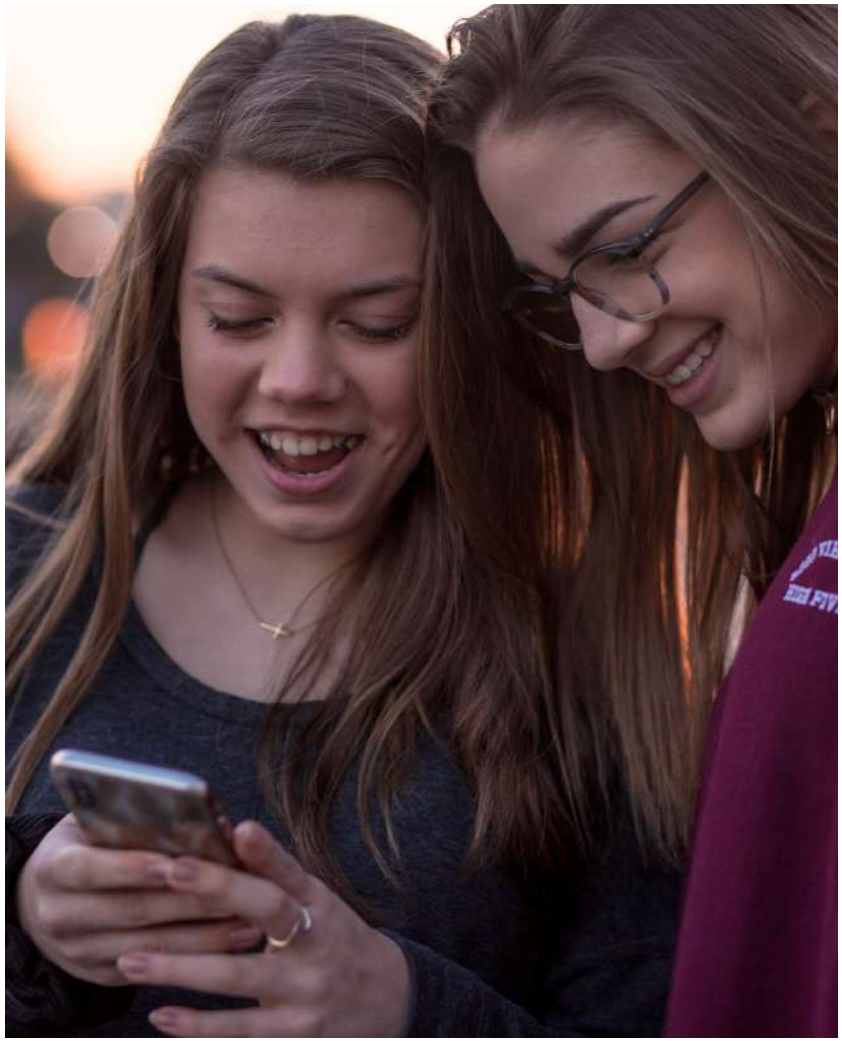
Sefton's locality model is a joined-up and collaborative way of working to help our residents achieve improved health, wellbeing and independence.

The locality early help model takes a whole family approach which helps to identify what needs to be done and what action needs to be taken, with a focus on strengths. Together we will look at what is going well, what could be better and what needs to happen to achieve improvement.

The localities delivery networks will help to facilitate much stronger collaboration and integration across universal and targeted services. This will include schools, GPs and other health services, the police, voluntary, faith and community sector agencies and a wide range of Council services such as Housing Options and Children's Social Care.

Working Together to Safeguard Children, 2018

'Where a child and family would benefit from co-ordinated support from more than one organisation or agency there should be an inter-agency assessment. These early help assessments should be evidence-based, be clear about the action to be taken and services to be provided and identify what help the child and family require to prevent needs escalating to a point where intervention would be needed through a statutory assessment...'



Delivery model for Early Help

To ensure we have a mature early help system we need to transform the way professionals work with each other and with families, and to develop the right culture, systems and behaviours that support the delivery of the model across the partnership. We have, through the work of the Sefton Safeguarding Children Board, a strong commitment by partners to undertake this transformation and to develop the right culture, systems and behaviours needed to have a mature early help system in place in Sefton.

The key areas for development during 2020-2025 are:

1. **Establish Effective Leadership, Partnership Working and Governance**

   There are many positive examples of multi-agency working across Sefton to deliver good outcomes for children and their families and we will continue to expand on this to focus on developing more effective streamlined and joined processes. Delivery and accountability for this Early Help Strategy and the Early Help Performance framework will move from Sefton Safeguarding Board to the Early Help Partnership Group, a sub group of the Health and Well-being Board. The Board will also have oversight of:

   - Each partner agency's response to implementation of this Strategy.
   - Developing an effective outcome-based performance management and quality assurance framework to measure impact.

2. **Establish easy to use Early Help online information and advice**

   In order to help children and their families and practitioners across the partnership to understand the wide range of information and services available we will build on the Sefton local offer website as a central portal to bring information together. This local offer website already provides information, advice and guidance to the public on a range of family issues, including support from partner agencies. Other online websites, advice centres, telephone helplines or supports and services not linked, will be connected to this so that families and practitioners can access these.

3. **Develop a suite of tools for early help practitioners to use – ensuring a whole family strength based consistent approach to working with children and families**

   To accompany the revised early help assessment and plan we will develop a suite of early help tools to assist practitioners to understand the child and family journey, consistently monitor and review children's progress, evaluate the impact of support and interventions offered to improve outcomes and how to measure a family's engagement and their satisfaction level.

4. **Develop effective and timely processes for sharing information between agencies**

   To enable early help to be more effective and ensuring the right help, at the right time, we will work with partners to remove barriers to effective working and ensure that families don't need to have a series of assessments before receiving the support they need to. We will:

   - Ensure we have in place clear information sharing arrangements
   - Ensure we are making the best use of IT systems and portals across agencies and departments

5. **Refresh structures and pathways that support the access to early help**

   The Early Help approach is embedded in the Assess-Plan-Review guidance for practitioners and is available to all practitioners through the Sefton Early Help website.

The Council's existing early help services have been realigned to localities and renamed to 'Family Wellbeing' creating a locality based, systemic, family key worker (casework) service to work with children and families deemed as intensive need under the continuum of need, including children deemed on the edge of escalation to statutory services and those stepped down from statutory services.

Parenting programmes will continue to be provided for practitioners working with children and families open to both statutory and early help services.

Locality based Early Help will continue to develop greater integration and alignment with communities and partner agencies, exploring co-location and/or coordination of processes with early years provisions, health, schools, children and adult substance misuse services and emotional and mental health services (those provided by voluntary, community and faith sectors.

This revised strategy also has key links with the approach for children with Special Education Needs and Disabilities (SEND) Sefton Children with SEND should be supported at the most appropriate level for their needs at the earliest point when these become apparent. Early help supports this approach and enables coordinated early support for children with SEND and their families.

We will work with commissioners and providers to ensure that early help informs the interventions required in each locality and across the borough and that these are developed in accordance with need and ensuring impact.

The multi-agency Task and Finish Group will develop and agree clear pathways to support access to early help and ensure children, families and practitioners have clear information on how to access early help.

6. **Develop a skilled and competent workforce across the partnership**

   Delivery of early help requires effective working between professionals and between services including an understanding of each other's role, responsibility, organisational culture and values. A lead worker forum will be launched to strengthen and enhance the Early Help offer, to build on the delivery of evidence-based practice. This includes:

- Awareness raising to ensure that the 'levels of need relating to risk' are clearly understood and communicated between professionals so that families can move between early help and specialist statutory services at the right time and when required.
- Information sharing and conversations between professionals to identify families who would benefit from early help.
- Implementing whole family approaches whilst keeping the child at the centre and undertaking strength-based assessments of families including effective engagement and conversations with children and their families.
- Holding and managing risk.
- Working with difficult to engage families.
- Embedding evidence-based approaches and interventions across the partnership – including sharing good practice and developing online resources for practitioners.
- Building relationships with and getting to know families.
- Reducing the number of 'hand-offs' and ensuring consistency of lead workers.

- Identifying and engage family support networks.
- Reflecting on their work with families and get different perspectives from managers and peers.
- Access training and learning opportunities to develop skills across the partnership.

The practice models include:

- Restorative based work across the children's workforce building relationships with children, young people and their families.
- Family Group Conferencing in Early Help and Children's Social Care.
- Motivational interviewing, focussing on strengths in the individual, and help them explore their own solutions to their behavioural issues.
- Understanding attachment and trauma informed practice across the workforce.
- Adverse Childhood Experiences training.

7. **Develop a joint commissioning framework for early help**

More joined up commissioning will achieve economies of scales savings and reduce duplication of services. The resources saved can be applied to any gaps in service delivery. This will include:

- Enabling, through established governance mechanisms, pooled resources to develop a broader joint commissioning framework across partner agencies to direct the commissioning intentions for early help whole family approaches and maximise best value.
- Develop an intelligence led approach to commissioning that draws together key public funding streams to develop a broader joint commissioning framework across partner agencies to direct the commissioning intentions for prevention and early help
- Ensure all stakeholders, including children and families, have a voice at every stage of the commissioning cycle and provide feedback to measure and review impact and enable redesigned services that better meet the needs of our children and families.

Conclusion

Our integrated strategy for early help builds on our previous achievements and takes us on a journey with families in Sefton to maximise their opportunities for the future. An implementation plan that supports it will help us to deliver success. Our early help journey will continue in partnership with statutory and voluntary partners, communities, and partnership with children, young people and their families.

Working Together to Safeguard Children, 2018

'A lead practitioner should undertake the assessment, provide help to the child and family, act as an advocate on their behalf and co-ordinate the delivery of support services. A GP, family support worker, school nurse, teacher, health visitor and/or special educational needs co-ordinator could undertake the lead practitioner role.'

Sefton Council

My Sefton

HEARD, HAPPY, HEALTHY, ACHIEVING

The plan for all children, young people and their families living in Sefton

Children and Young People's Plan
2020/25

"A hundred years from now, it will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove..... but the world may be different because I was important in the life of a child."

Forest E Witcraft

Foreword and Introduction

Welcome to 'My Sefton: heard, happy, healthy, achieving', our 2020-2025 plan for all children, young people and their families that sets out how we intend to maximize the health and wellbeing of all our children and young people living in Sefton

Together, we at Sefton Council, NHS South Sefton Clinical Commissioning Group (CCG) and NHS Southport and Formby CCG, have agreed a series of priorities for future services and support. These priorities are based on what children, young people, their families and their Carers have told us of their experiences and what we know about their current care.

Sefton Council led on the development of an exciting partnership vision for the Borough of Sefton called Sefton 2030. When developing the vision partners worked closely with our communities, including children and young people, to understand what was important to them.

This is our single strategic and overarching plan for all services which affect children and young people across Sefton. It sets out how the Council, with its strategic partners, intends to achieve improvements.

We have used information from our Joint Strategic Needs Assessment to inform the plan and will seek to ensure that children and young people's needs are understood and met. This information together with what we already know about our area from previous work and conversations has informed the priorities in this document. This plan, therefore, has been written around the four themes of:

- Heard
- Happy
- Healthy
- Achieving

We have also set out clear actions for how we will address the priorities under each theme and how we will measure the progress of these actions. While it is important to measure progress, we acknowledge there has to be a balance with how children and young people experience life and what is important to them. These priorities incorporate the seven principles for corporate parenting:

1. To act in the best interests, and promote the physical and mental health and well-being, of those children and young people.
2. To encourage children and young people to express their views, wishes and feelings.
3. To consider the views, wishes and feelings of children and young people.
4. To help children and young people gain access to and make the best use, of services provided by the local authority.
5. To promote high aspirations, and seek to secure the best outcomes, for children and young people.

6. For children and young people to be safe, and for stability in their home lives, relationships and education or work, and
7. To prepare children and young people for adulthood and independent living

Alongside this, we have a plan for the whole of the local NHS called Sefton 2gether, led by the CCGs. Like Imagine Sefton, the plan is rooted in all that we know from the JSNA and then goes further, based on discussions with our health and care partners in the borough and from speaking with our residents about what they would like for the future. Sefton 2gether's ambitious priorities for children, young people, their families and Carers are reflected in and complement those contained in this plan – My Sefton: happy, healthy, achieving, heard.

We know we cannot achieve our priorities without working together with our wider partners across health and care in Sefton. Working together is important in times of challenge, austerity has seen significant cuts in the money going to public services so there is a need to work differently and achieve better with less. Organisations from the public sector, schools, voluntary, community and private sector have been working together to provide support to children and young people and their families as we understand that it is our collective responsibility to ensure we can create the right conditions for children and young people to thrive in Sefton.

We recognise that each organisation is just one part of a whole system and that by working together we can make the best use of the resources available to provide support where it is most needed.

These organisations are committed to maintaining, strengthening and maximising partnership working to best support the children and young people of Sefton. This plan will build upon the strength we have in Sefton around our partnership working and what we already do well.

Fiona Taylor, Chief officer of NHS South Sefton Clinical Commissioning Group (CCG) and NHS Southport and Formby CCG, Vicky Buchannan, Interim Director of Children's Social Care and Education, Cllr John Joseph Kelly

What's the story in Sefton?

The Sefton Children's JSNA, complete in August 2018 highlights the following key points for us grouped by our themes:

Heard:	Happy:	Healthy:	Achieving:
Child Sexual Exploitation referrals fluctuate with the highest count being 97 in Quarter 4 of 2015/16 and the lowest 43 in Q3 of 2016/17.	Children looked after rate per 10,00 was 85 in 2017, compared to 61.7 nationally again this continues to rise.	In Sefton in 2017 2.4% of Pupils had a Statement of Special Educational Needs or EHC Plan, compared to a national average of 2.8%	In 2017 95% benefited from funded early education (24% more than the English average). 98% of 3 and 4 year olds also benefited. Pupils in these early years phase development attainment was in line with national averages.
The Carers Trust 2019 reported that there are an estimated 700'000 young Carers in the UK, 68% are bullied and miss an average of 48 schools' days per year, 48% reported being stressed. Sefton Carers support 600 young carers.	In 2016/17 the rate of Family Homelessness was at 0.3 per 1000, nationally this was 1.9. This equates to a count of 31 households. For Young people aged 16 -24 this rate was 0.16 per 100,000 in 2016/17 (19 individuals) below national average.	In 2017 3.6% of our pupils had a Learning Disability (this figure has consistently been around 4% since 2013).	In Key Stage 4 the % of Pupils attaining Grade 9 to 5 or 9 to 4 in English and Maths was below the national average at 37% and 60% (English averages were 43% and 64% in 2016/17). 94% went on to education or training after this stage
	The of Children living in poverty in 2017/18 in Bootle was 28% before housing costs and 31% after housing costs, for Sefton Central this is recorded as 15 % and 19% and for Southport 21 % and 30%.	In 2017 15.5 children in every 1000 pupils enrolled in one of Sefton's state funded schools were recognised as having autistic spectrum disorders, this has risen from 14.4 in 2015. Rates are continually higher than	In Key Stage 2 pupils attainment in Reading, writing and Maths were all above national averages.

	Hospital Admissions for Mental Health Conditions are higher than national averages at 97.5 per 100,000 in 2016/17 down from 146.6 in the previous year. 1 in 10 Children are affected by Mental Health Problems. Self-Harm has increased and is higher than national averages	England and the North West	Our LA's Overall Absence has decreased by 0.16% from 4.94% in 2017/18 to 4.78% in 2018/19, which is 0.24% higher than the National average of 4.54% and equivalent to 21,128 more missed sessions in your LA than the National cohort, with pupils at our LA missing an average of 12.3 sessions (this is 1.7 more than the National cohort)Our LA's average for the last 3 academic years is 4.88% and we have been consistently higher than the National average in the last 3 academic years for Overall Absence.
			The rate of NEET for 16 -24 years olds was at 4.5 % in 2017. This figure has improved between 2013 and 2017 but still remains higher than national averages
			First time entrants to the Youth Justice System aged 10 – 17 was at 220.2 in 2016 this had fallen since 2012 when it was at 578.7. The rates are below national averages

The overarching aims for starting well in Sefton, taken from the Health and Well Strategy:

- Every child will achieve the best start in their first 1001 days
- Education and training will enable every young person to unlock the door to more choices and opportunities
- Every child and young person will have a successful transition to adulthood

In 2025 we will know we have made a difference by raising the % of Children achieving a good level of development from 69% to 74%. Continue to reduce the proportion of our 16 – 17 Not in Education and Training. Improve the experience of Transitions experience as measured by our annual survey and by having a fully adopted joint transitions pathway.

About the plan

We have looked at the last plan and what is still important to our children, young people and their families. This plan has been shaped by the analysis of our performance and progress to date, alongside the trends identified in the Joint Strategic Needs Assessment (JSNA) which allows us to establish trends across a wide range of data.

More importantly through Consultation with a wide range of Youth Groups, Schools and Key Stakeholders and Professionals.

we have also listened and what children, young people and families tell us has led us to identify a number of priorities for action over the course of this Plan. We recognise achievements from the last plan to include:

- Early Years Foundation Stage (EYFS), achieving a good level of development, we are the highest in the North West (NW) and above the regional average
- Sefton's Not in Employment Education or Training (NEET) group has improved over the 3 year period, performing better that Liverpool City Region (LCR) and staying in line with the North West
- Sefton has consistently exceeded the England and North-West numbers, for children benefitting from the "Two Year Old Offer". Since the introduction of the Two Year Old Offer in 2009, Sefton has worked in close partnership with Health and Early Years settings to identify and engage with the families of rising two year old's who meet the criteria
- We have seen a decrease in young people being involved with Anti-Social Behaviour, one significant reason could be we have issued Gang Injunctions along with the police, which have significantly deceased youth Anti-Social Behaviour in the Area. (80% of the cases are adults)

We recognise that some areas from our previous plan still need our focus and these are reflected in the 2020 – 2025 plan.

Child health and wellbeing are dependent on supportive and safe homes; studies repeatedly show the importance of having at least one supportive caring adult to establishing childhood resilience. This is critical so that children are able to bounce back when difficulty threatens

that happiness. Through access to play, leisure, sport, cultural activities and positive interaction in families that spend time together, there are opportunities for happy memories to be made and resilient capacities to be built, all of which greatly enhance the foundation for happiness and lifelong wellbeing.

Our ambition is to improve outcomes for all children as we want to break the link between a person's background and where they get to in life.

We will be child focused, children and young people are our primary concern, we will listen and respond to children and young people and we will focus on strengths and building resilience. We will support our children, young people and their families to lead healthy lifestyles and have good emotional wellbeing and mental health.

We will do this through the actions in 12 priority areas under each of the headings Heard, Happy, Healthy, and Achieving shown below. These 12 priorities are based on what the evidence in the JSNA and our consultation tells us we need to get better at.

We have identified a short set of indicators where we want to see real positive change. There is a detailed action plan being developed in draft which describes the actions in terms of steps of delivery and impact Some of these we are able to deliver through the services we directly provide, and others require us to a combined effort to influence wider changes. Importantly, we will always look at the story behind the data through the eyes and voice of children, young people and families.

Heard

Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.

United Nations Convention on the rights of a child. Article 12

These are our priorities:

Priority 1. Ensure children's voices are heard and families will get the right support and help at the right time.

We will give children and young people opportunities to be engaged in decision making processes and give them as much influence as possible.

Children and young people will be treated respectfully as we recognise that children, young people, parents and Carers (including Young Carers) are experts by experience

We will take time to listen, it is a two-way conversation.

We will do what we say we are going to do and recognise that involvement is a continuous process and not just a one off exercise.

Priority 2. Engage with a wide range of youth networks and groups that support young people

We will work with children and young people to understand what works for them in terms of involvement and will we also accept. that children and young people are not always going to tell us what we want to hear – in the way we want to hear it

We will be respectful of difference and celebrate diversity.

Based on our localities model and primary care networks we will continue to provide universal services that are accessible to everyone in the borough.

Priority 3. Place children and young people at the core of decisions we make about them.

We will ensure that children and young people will always be central to decisions we make about them and their journeys will be shaped by their voice and experience. Children will be supported by professionals they trust who listen to them, made to feel their opinion is valued and take actions to meet their needs and tackle concerns they raise.

Young people say: Everyone wants to feel safe (Imagine Sefton 2030). Sefton value, we listen value and respect each others views. Look at info from youth groups e.g. Symbol, Chameleons.

The actions we will take:

We will listen to children and young people by ensuring that barriers to participation and progress are addressed using multiple techniques and methods so we can hear the voice of the child. We will work closely with Young Advisers at Sefton CVS and key youth groups in the Borough to ask questions, clarify understanding and give them the opportunities to be engaged in decision making processes and have as much influence as possible. We will support families to access the right help at the right time, through activity such as the redesign of integrated advocacy services, improving our local offer, and ensuring equality of access to our universal services. We will help build tolerant communities that value all children and young people as members and give them positive opportunities to contribute. We will be joined up and inclusive and challenge poor practice and accept challenge constructively. More children and young people will express satisfaction with our services and we can evidence improvements. The SEND continuous improvement work has the voice of the child at its heart.

An action plan will be developed to show where any measures we look at are held to account.

Sefton Council

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Southport and Formby Clinical Commissioning Group

Happy

Every child has the right to relax, play and take part in a wide range of cultural and artistic activities.
United Nations Convention on the rights of a child, Article 31

These are our priorities.

Priority 4. Ensure positive emotional health and wellbeing of children and young people by empowering families to be resilient.

We will create and promote children and young people's emotional health and wellbeing by supporting them and their families to make positive choices. We will have strength informed approaches to ensure engagement and strengthening of families including promoting healthy relationships.

We will improve access to the right support from the right service at the right time and build on the strength of families and their inclusive networks.

This will be a key consideration at points of transition.

Priority 5. Protect those at risk of harm

We want all children and young people to be safe and to feel safe. We will help children live in safe and supportive families and ensure the most vulnerable are protected by tackling those factors which risk harming their life chances, including those children and Young People acting as carers. We will reduce the impact on children living in households which experience neglect, domestic abuse or parental substance use by the provision of a range of support and services. We will prevent and safeguard all children from exploitation and safeguard individual children who are identified as at risk.

We will work to address the concerns expressed to us through the consultation on Gangs and Knife Crime in our communities.

Priority 6. Encourage fun, happiness and enjoyment of life

We want children and young people to live in a good environment that they can enjoy. Sefton is a great place to live and grow up. We have a wealth of resources and assets in the community such as the coast and green spaces that can be used for pleasure, sport and other leisure opportunities.

We will encourage and provide or commission a diverse range of culture, exercise and socially connective activities in our borough ensuring a One Council approach with Green Sefton and Localities

Young people say: Being near the river and coast makes me feel happy and well. Young People told us feeling safe has a direct link to feeling happy. "If you are happy all other things will fall into place"

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Southport and Formby Clinical Commissioning Group

The actions we will take:

We will have a family approach and will work with our partners to develop vibrant communities that take responsibility for the aspirations, opportunities and achievements of their young people so families and children experience a positive home life.

We will promote partnership working including joint commissioning so we can invest in children and young people's futures. We will improve information and advice on access to play, leisure, sport and cultural opportunities. We will utilise Early Intervention and Prevention services such as the roll out of Adverse Childhood Experiences (ACE's) working to help build resilience and strengthen protective factors in the lives of children and young people and their families to reduce the impact of these experiences on future life chances.

We want to develop a confident and competent workforce to ensure all professionals working with children and young people have appropriate awareness, training and ongoing support, that's built around the needs and outcomes of each individual. The outcomes and impact we are aiming for will be monitored by the Health and Wellbeing Board to ensure we are supporting positive social connections and relationships.

Sefton Council

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Healthy

Every child has the right to the best possible health, (United Nations Convention on the rights of a child, Article 24)

These are our priorities:

Priority 7. To enable positive mental health and Wellbeing through prevention where ever possible and to provide timely support and access to services when needed.

We will do all we can to identify problems early as we know the vast majority of mental health problems experienced in adult life emerge before young people reach adulthood. We will ensure high quality specialist services for those who need them.

We will strengthen the protective factors of mental health and wellbeing by enabling children and young people to develop skills around building friendship, self-esteem, resilience and mindset.

Priority 8. To Enable children's health and development.

We will promote positive health choices by parents, especially during pregnancy. We will encourage care that keeps children healthy and safe and promote children's health and development. Where problems are identified in health and development they can get support as early as possible. Focusing efforts on the 1st 1000 days and school readiness.

We will encourage children and young people to achieve and maintain a healthy weight through education, support and commissioned services.

Priority 9. Reduce health inequalities so children and young people can achieve good health.

We will endeavour to offer the right infrastructure to promote good health behaviours and reduce lifestyle factors that lead to early illness such as smoking and poor diet that will affect young people into adulthood.

We will reduce a range of risk taking behaviours including, alcohol and other drug use and unhealthy Sexual Activity.

We will take a preventative approach to manage rising demand across education, health, social care and SEND from the earliest point in a child's life through focused operational improvement in this area and ensuring the system works together, for example linking economic growth Agenda, Living Well Sefton and Active Sefton to

contribute to the environment we need to achieve this.

Young people say: “I play rugby”; e.g. being fit and healthy (Sefton Imagine 2030), more youth friendly things for people to do are our priorities.

The 2019 Health and Wellbeing Strategy Consultation identified the top issue under “Start Well, Grow Well” to be help Children and Young People with Mental Health Problems including problems with drink drugs and self harm. The CYPP consultation told us “if children are protected and preventions have been put in place children will have better mental health”

The actions we will take:

We want children and young people to be healthy and will promote healthy eating, delivery of the North Mersey Prevention Programme and a review of mental health services recognising the importance and significance of getting this right. We will seek to reduce hospital admissions for children and young people around alcohol and will continue to commission services and use campaigns such as Responsible Drinking and Challenge 25.

We will develop locality profiles in order to understand what the current risks are to young people including that young people know about healthy relationships and issues relating to consent. This will allow us to provide a quality provision targeted to local needs and inequalities and we will also focus on transitions from primary to secondary school, starting school further education and working life to improve outcomes. We will clearly measure and demonstrate improved relevant Child Health Profiles Indicators from the Baseline.

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Southport and Formby Clinical Commissioning Group

Achieving

Every child has the right to an education. Education must develop every child's personality, talents and abilities to the full.
United Nations Convention on the rights of a child, Articles 28 and 29

These are our priorities:

Priority 10. Children are ready for school

A great start will shape children's lifelong health and wellbeing. We will ensure that all children are ready for school with good social and emotional development. We will secure and sustain better all-round outcomes for babies and children which narrows the gap between vulnerable children and others.

We will take a preventative approach from the earliest point in a child's life in order that we can identify problems in children's health and development so they can get help with their problems as early as possible.

Priority 11. Raise achievement and ensure young people have the life skills so they are well prepared for adulthood.

We will have a clear understanding of the aspirations of our young people and what they have told us is important to them. We will respect and encourage the hopes and dreams of the children and young people we work with.

We know high quality education is the greatest liberator so want all pupils to make at least "good" progress in every year of their education. We will ensure that all children attend good or better educational settings in Sefton and barriers to participation and progress are addressed. There will be a broad and balanced curriculum equipping them with the life skills they need to be independent and successful as an adult. These skills and opportunities to achieve will also value the contribution of sport, cultural,

Priority 12. Children and young people with Special Educational Needs and/or disabilities achieve their full potential

We want children with complex individual needs to have the best life chances. We will enhance joint commissioning of support between education, health and care services for children with special educational needs and disabilities. To ensure services work together. We will ensure that all parts of the Sefton Send Local offer work together to meet the needs of children and young people with SEND and that they achieve their full potential and that people know the range of services available to them. We will ensure all children have access to an educational setting that is appropriate to their needs, including those with SEND and social, emotional and behavioural difficulties. We will from the earliest point in a child's life encourage independence, where appropriate, and ensure families have timely

social and health education in preparing young people for their future. When preparing for adulthood we will have pathways to employment that ensure they are moving towards good quality sustainable work. We will focus on ensuring our children leave school with the right skills such as financial management, how to deal with bullying and citizenship, and maintaining wellbeing when carrying out caring responsibilities.

access to support so their experience improves and the needs of their children are identified early and met.

We will encourage equalities of access to universal services so all Children and Young People with SEND and/or Autism can gain maximum benefit from what Sefton has to offer.

Through our consultation of this plan Young people told us we need to instil the right life skills and not judge young people by numbers and grades only.

The actions we will take:

We want young people to leave school with the appropriate skills and qualifications they need and the opportunity to access, training, apprenticeships and employment which will include working with skills and employment resources and local colleges to improve access to learning and meaningful opportunities. The local offer will be kept up to date, refreshed regularly and promoted to ensure we are providing good information, advice and guidance to young people and their families.

We will continue to provide universal services with a focus on specific groups and communities and equality of access for all through this plan and the SEND Improvement Plan and SEND Joint Commissioning Plan to ensure delivery of these ambitions

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Delivering our Vision

The Health and Wellbeing Board (incorporating our Children's Trust) gives overarching vision through the Health and Wellbeing Strategy and oversees the delivery of the Children and Young Peoples Plan. Its gives overarching Governance and Accountability with membership from across Health, Social Care, the third sector and plans to include Police and Housing.

The Children and Young Peoples plan will be delivered thorough the work of the Children's Improvement Board and Operational Service Improvement Plans and through the development of a comprehensive Integrated Commissioning plan.

The Commissioning plan will be clear of our demand, supply and unmet need and our intentions to work with the market, and how we manage the complex range of services across the Council, Health and wider partners to meet the needs of our Children within the challenging budget envelope, working on a regional basis where the benefits are clear and ensure seamless delivery of services whether the need is health or Social Care in the most effective way.

Sefton Council

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Southport and Formby Clinical Commissioning Group

Useful Links:

PHE Child Health Profile for Sefton
https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/1938132696/pat/6/par/E12000002/ati/101/are/E07000026

Thrive Model
http://implementingthrive.org/about-us/the-thrive-framework/

Early Help Strategy **https://www.sefton.gov.uk/your-council/plans-policies/children,-young-people-and-families.aspx**

Health and Wellbeing Strategy **https://www.sefton.gov.uk/your-council/plans-policies.aspx**

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