Southport and Ormskirk Hospital NHS Trust

AGENDA
BOARD OF DIRECTORS' MEETING

To be held at 0900 on Wednesday 02 December 2020

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
TB186/20 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB187/20 (D)	**Declaration of interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB188/20 (D)	**Minutes of the previous meeting** a) Meeting held on 04 November 2020 *Purpose: To **approve** the minutes of the previous meetings*	No	*Chair*	*10 mins*
TB189/20 (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*	
TB190/20 (V)	**Patient Story:** *Purpose: To **receive** feedback*	*No*	*DoN*	*20 mins*
STRATEGIC CONTEXT				**0930**
TB191/20 (D)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*10 mins*
TB192/20 (D)	**Chief Executive's Report** *Purpose : To **receive** an update on key issues from the CEO*	*No*	*CEO*	*10 mins*
COVID-19 UPDATE				**0950**
TB193/20 (D/ P)	**Covid-19 Update** a) Covid-19 Update b) Infection and Prevention Control Assurance Framework *Purpose: To **receive** the Covid-19 updates*	*No*	*Execs DoN*	*35 mins*

INTEGRATED PERFORMANCE				**1025**
TB194/20 (D)	**Integrated Performance Report (IPR) Summary** *Purpose: To **receive** the IPR for assurance.*	*No*	*CEO / DCEO*	*5 Mins*
QUALITY & SAFETY				**1030**
TB195/20 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report b) Quality and Safety Performance Report c) Patient Experience Strategy *Purpose : To **receive** the reports for information and assurance*	*No*	*Cttee Chair DoN/MD*	*20 mins*
TB196/20 (D)	**Quality Accounts** *Purpose : To **approve** the Draft Quality Account*	*No*	*DoN*	*10 Mins*
TB197/20 (P)	**Maternity 6 monthly update** *Purpose: To **receive** the presentation for assurance*	*No*	*Head of Midwifery*	*15 mins*
TB198/20 (D)	**Medical Director's Reports** a) Learning from Deaths Quarterly Report (Q.1 & Q.2) b) Medical Vacancies Report c) Medical Appraisal and Revalidation Reports *Purpose : To **receive** the Medical Reports*	*No*	*MD*	*10 Mins*
OPERATIONS AND FINANCE				***1125***
TB199/20 (D)	**Finance, Performance and Investment** a) Committee AAA Highlight Report b) Operational Performance Report *c)* Financial Performance Report *Purpose : To **receive** the reports for information and assurance*	No	*Cttee Chair IDoF*	*15 mins*
WORKFORCE				**1140**
TB200/20 (D)	**Workforce Reports** a) Committee AAA Highlight Report *b)* Workforce Performance Report *Purpose: To **receive** the reports for information and assurance.*	*No*	*Cttee Chair DoHR*	*15 mins*
CORPORATE GOVERNANCE				**1155**
TB201/20	**Corporate Governance Reports** a) Scheme of Reservation and Delegation b) Corporate Governance Structures	*No*	*ADCG*	*15 mins*

*Purpose: To **approve** the Corporate Governance Reports*

ITEMS FOR INFORMATION			**1210**
CONCLUDING BUSINESS			**1210**
TB203/20 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*	Public	*5 mins*
TB204/20 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*	Chair	*3 mins*
TB205/20 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	Chair	*2 mins*
	Date of next meeting: 0900, Wednesday 03 February 2021		***1220 close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

Chair

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: Neil Masom

NHS Southport and Ormskirk Hospital NHS Trust

Register of Interests Declared by the Board of Directors as at 01 December 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**	**5 January 2020**
BOTTOMLEY, Mrs Yvonne	Interim Director of Finance	**Emmett Cannell Consulting Limited** **Unity Theatre Liverpool**	**Emmett Cannell Consulting Limited**	**Emmett Cannell Consulting Limited**	**Hospice of the Good Shepherd (Chester)**	**Nil**	**Nil**	**Nil**	**Nil**	**27 October 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**
CHRISTIAN, Mr Steven	Deputy CEO & Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**27 February 2020**

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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 Clinical Case Worker (bank)** 2020 to date	**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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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**	**27 April 2020**
LEES Ms Bridget	Director of Nursing, Midwifery and Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Spouse employed as 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**
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**

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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**	**Nil**	Nil	**Nil**	**Nil**	**Trustee – Age Concern**	**5 February 2020**
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**

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Draft Minutes of the Board of Directors' Meeting
held on Microsoft Teams / Livestream
Wednesday 04 November 2020
(Subject to the approval of the Board on 02 December 2020)

Members Present

Mr Neil Masom	Chair
Mrs Trish Armstrong-Child	Chief Executive
Mr Jim Birrell	Non-Executive Director
Mrs Yvonne Bottomley	Interim Director of Finance
Dr David Bricknell	Non-Executive Director
Mr Steve Christian	Deputy Chief Executive/ Executive Director of Strategy
Mrs Pauline Gibson	Non-Executive Director Designate
Mrs Julie Gorry	Non-Executive Director
Dr Terry Hankin	Executive Medical Director
Ms Bridget Lees	Executive Director of Nursing, Midwifery and Therapies
Mr Graham Pollard	Non-Executive Director
Mr Gurpreet Singh	Non-Executive Director

In Attendance

Mrs Laura Atherton	Outpatient Therapies & Joint Health Service Lead *(Item TB170/20)*
Mr Tony Ellis	Communications and Marketing Manager
Mrs Sharon Katema	Associate Director of Corporate Governance
Ms Suzy Ning	Project Director – Acute Sustainability *(Item PB050/20)*
Mr Simon Regan	Deputy Director of Quality, Risk and Assurance *(Item TB149/20)*
Ms Jacqueline Robison	SCT Comms and Engagement Strategic Lead *(Item PB050/20)*
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance

Apologies

Mr Steve Shanahan	Executive Director of Finance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB166/20	**Chair's Welcome and Note of Apologies**	
	Mr Masom welcomed all in attendance. The Board noted apologies for absence from Mr Shanahan.	
TB167/20	**Declaration of interests**	
	There were no declarations of interests in relation to the agenda items. **RESOLVED:** The Register of Interests was **approved.**	
TB168/20	**Minutes of the previous meetings**	
	The Board reviewed the minutes of the meeting held on 07 October 2020 and approved them as a correct and accurate record of proceedings.	

	RESOLVED: The Board **approved** the minutes from the meeting held on 07 October 2020.	
TB169/20	**Matters Arising and Action Logs**	
	The Board considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. **RESOLVED:** The Board **approved** the action log	
TB170/20	**Patient's Story**	
	(Mrs Atherton joined the meeting) Ms Lees introduced the pre-recorded patient story, which provided an insight into a patient's experience following referral by his GP to the Musculoskeletal (MSK) service. Mr Paul Standson recounted his experience of receiving care and treatment online as one of the first patients to trial the Attend Anywhere virtual appointment service. He outlined the ease with which he had been able to secure an appointment despite an initial timescale of five weeks unless if there was a cancellation. Overall, Mr Standson had found the service supportive adding that despite doing the exercises through video link, he did not feel isolated. Mrs Atherton highlighted that Attend Anywhere had enabled the service to continue to offer clinics to patients throughout the first wave of Covid-19. **RESOLVED:** The Board **received** the patient story. *(Mrs Atherton left the meeting)*	
STRATEGIC CONTEXT		
TB171/20	**Chair's Report**	
	Mr Masom presented the report which highlighted activities undertaken since the previous meeting. He outlined that the North West region was continuing to see a significant increase in Covid-19 admissions which placed an enormous strain on staff and impacted the recovery and restoration of services. The emphasis of the call and a priority of the Board was around staff welfare which was now being addressed at the Workforce Committee. The Trust's first Virtual Open Week had been held during October with a series of videos being shared on the Trust's website and social media platforms. Mr Masom drew attention to the innovative ways that teams were applying in order to show the ongoing activities within the Trust and how care continued to be delivered and recommended the most viewed video around caring for patients diagnosed with Covid-19 and a day in the life of a porter.	

DRAFT

	On behalf of the Board, Mr Masom formally congratulated Mr Singh for receiving an MBE in the Queen's Birthday Honours for services to healthcare, diversity and equality. **RESOLVED:** The Board **received** the Chair's update.	
TB172/20	**Chief Executive's Report**	
	Mrs Armstrong-Child presented the report which provided an overview of activity and issues that had occurred within the Trust. Advising that the date for the Time to Shine Awards was yet to be finalised, Mrs Armstrong-Child drew attention to the following awards and recognition received since the last meeting: • Kath Todd and Tracy Collins were the joint recipients of the Thanks a Bunch award. • The Trust was awarded Excellence in Informatics Level 1 accreditation by the North West Skills Development Network. • Special congratulations were extended to Jackie Bailey who had donated her 80th pint of blood • Heath Education England had just announced the list of North West Doctors awards and the Trust had 5 winners and 4 highly commended. Mrs Armstrong-Child outlined that the Critical Care unit had reached full capacity and had moved into the first stage of the Surge Plan. Currently elective programmes were still running but these might have to be reduced if the need to further extend critical care capacity arose. A collaborative approach to the Shaping Care Together Programme is underway with the Trust now working with commissioners to develop a comprehensive communication and engagement plan. Mrs Armstrong-Child echoed the chair's congratulations to Mr Singh and to Mrs Stark, currently Associate Director of Planned Care, on her secondment as Interim Deputy Chief Operating Officer. With regards to the nosocomial infections, Mrs Armstrong-Child advised that NHSI/E had undertaken an Infection Prevention and Control assurance visit, and whilst the report was expected shortly, the regulators had commended the Trust for being forward thinking. She advised that to keep infections at the lowest possible rate, all patients were swabbed on arrival and again at five days if they tested negative. Mr Singh thanked Mrs Armstrong-Child for her kind words and added that he saw the award as an award for all members of the Trust. He further commented on the awards received by the Specialist and Associate Specialist SAS doctors adding that they were the unrecognised backbone of the NHS. **RESOLVED** The Board **received** the Chief Executive's Report	

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COVID-19 UPDATE		
TB173/20	**Covid-19 Update**	
	a) Covid-19 Update Mrs Armstrong-Child provided an overview of the presentation which presented an up to date position on all items discussed at the daily Gold Command meetings. Mrs Armstrong-Child led the Executive Team in delivering a presentation that outlined the ways in which the Trust was preparing for the winter season with added pressures of the second wave of Covid-19. Dr Hankin provided a position statement with regards to a press article which suggested that trusts had rationed care for some patients during the first wave of Covid-19. He advised that the Trust had not restricted in any form the care provided to any patients. Dr Hankin advised that patients were admitted from the Emergency Department (ED) into the Critical Care unit however, the situation during the second wave saw patients being transferred from wards to Critical Care. Dr Hankin advised that whilst there was a reduction in the number of deaths due to Covid-19, there had been a large increase in numbers attending Critical Care resulting in a collaborative effort across the region Ms Lees provided an overview of the work being undertaken within Quality advising that: • There had been a focus on the lessons learnt during the first wave and that the Infection Prevention and Control (IPC) Assurance Framework had been updated to include this. • The Patient Advice and Liaison Service (PALS) had been launched over the summer to support the community both virtually and on site. The team had made over 1,000 contacts since the introduction of the service. • Whilst visiting restrictions remained in place, infection rates in the community and other trusts were continually reviewed to ensure the guidance and consistency were maintained across the region • Other measures that have been introduced include: o One-way systems across all areas of the Trust o Ward zones – red, amber and green with clear guidance in all areas for both staff and patients o Track and Trace QR codes in waiting areas where required o Staff wearing masks in all areas The Trust had taken part in the rapid access swabs initiative and there was a possibility that this scheme would be extended. The Trust had invested in Redirooms (popup isolation areas) as well as increased side room capacity. There had also been further investment in domestic services with the purchase of UV light cleaning technology. The daily SitRep had been an invaluable tool and had allowed the Trust to create surge plans as well as reach out to community partners in any	

hotspots.

Mrs Royds delivered the Workforce update advising that increasing sickness levels were an issue amongst trusts within the North West which was experiencing the highest levels of sickness in the country. It was noted that whilst staff sickness had increased to just over 10%, 3.5% related to Covid-19 and the remainder included staff that were previously shielding and had now moved to sickness. The Health and Wellbeing team continued to support staff upon their return to work and were exploring available redeployment options and initiatives which included:

- The Insight program – a 24/7 online support service that offered online counselling as well as legal and financial support
- Daily themes, sharing good news and resources on social media
- The development of a Supporting Teams toolkit that included coping strategies
- Organisational Development (OD), Human Resources (HR) and Occupational Health (OH) intervention in hotspot areas with the appropriate support measure

Mrs Royds commended the HWB team and the Project Management Office for their support during the asymptomatic staff swabbing exercise. The Trust had managed to swab 1,185 (93,7%) of patient facing staff within two weeks and had saw a positivity rate of c1.64%.

Mr Christian provided a summary of the winter plan and the expected challenges in the lead up to winter. The postponement of elective services during the first wave of Covid-19 had resulted in a backlog and the Trust, like many others, was facing the unprecedented challenge of service restoration coupled with constraints around improved theatre usage and staff absences. As part of the 2020/21 Winter Plan the Same-Day Emergency Care Clinic had been launched following the temporary relocation of the Medical Day Unit (MDU) to a purpose-designed area at Ormskirk.

Mr Masom thanked the Executive Team for a clear and concise presentation and commented that the Trust had been recognised throughout the region for their work around the restoration of services.

b) Infection, Prevention and Control (IPC) Assurance Framework

Ms Lees presented the updated Infection, Prevention and Control Assurance Framework which provided assurance on the Trust's compliance across the majority of areas and that systems and processes were in place to manage and monitor IPC guidance and identify risks. She advised that the IPC Framework was regularly reviewed to reflect progress on mitigating actions and gaps in compliance against any new or amended guidance. Updates would continue to be presented to the IPC Assurance Group and the Quality and Safety Committee.

RESOLVED

The Board **received** the Covid-19 update.

INTEGRATED PERFORMANCE		
TB174/20	**Integrated Performance Report (IPR) Summary**	
	Mr Christian presented the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local priorities. A narrative writing training sessions was scheduled with Executives and Deputy Directors. Mr Christian advised that it was refreshing to note that the Southport IPR dashboard had been cited as an example of best practice and some trusts had contacted the Trust for some shared learning. **RESOLVED:** The Board **received** the IPR Summary Report	
QUALITY AND SAFETY		
TB175/20	**Quality and Safety Reports**	
	a) Committee AAA Highlight Report Dr Bricknell presented the AAA highlight report from the Quality and Safety Committee meeting held on 26 October. The Trust has stayed at the low end of the national range for mortality for the last 12 months. Mr Masom advised the meeting that he had circulated a copy of the self-appraisal of Trust's performance over the last 12 months and commented that he had received positive feedback on the quality journey from the North West Regional Director. **b) Quality and Safety Performance Report** Ms Lees presented the Quality and Safety Performance report advising that the current target for Caesarean section rates were not aligned to the national and regional rates. She added that this had been discussed at the Performance, Improvement and Development Assurance (PIDA) Board. The increase in turnaround time and quality of responses to Complaints were noted. **c) Freedom to Speak Up (FTSU) Quarterly Report (Q1)** Ms Lees presented the report which provided an update on concerns raised to the FTSU Guardian during quarter one of 2020/21. She highlighted that staff continued to use the FTSU service despite the impact of Covid-19 which provided assurance that the Trust continued to deliver a good quality service. The value of this service was noted as an important part of becoming a Well Led organisation. The regular meetings with the FTSUG and champions provided an invaluable insight into emerging themes and trends such as issues around relationships. It was noted that the Workforce Committee was looking at a piece of work around a Civility Charter which would be matched to the SCOPE values.	

	RESOLVED: The Board **received** the Quality and Safety reports.	
TB176/20	**Quality Improvement Plan**	
	Ms Lees presented the Quality Improvement Plan which provided a progress update against the Trust's Quality Priorities. She drew attention to the issues around expired medication which had been highlighted at the last inspection by the Care Quality Commission (CQC) as an area requiring additional focus. Ms Lees advised that the key quality measures had started to come through the Perfect Ward dashboard but there were still areas outstanding. The first iteration of the Perfect Ward dashboard would be presented at the February meeting following the Quality and Safety Committee. **ACTION:** An overview of perfect ward to be presented to Board in February 2021. **RESOLVED:** The Board **received** the Quality Improvement Plan.	DON
OPERATIONS AND FINANCE		
TB177/20	**Finance, Performance and Investment**	
	a) Committee AAA Highlight Report Mr Pollard presented the key issues highlight report from the Committee meeting held on 26 October. He drew attention to the alert regarding funding for out of hospital schemes noting that, whilst the CCG and local authorities had confirmed funding for the schemes detailed within the system winter plan, concerns regarding delivery of these schemes remained. The Trust has raised this concern with the commissioners, regulator, and the local authorities. The Committee took assurance from the IPR exception report as it had highlighted areas for concern for the first time resulting in focussed discussions within the meeting. **b) Operational Performance Report** Mr Christian presented the Operational Performance Report which provided a summary of operational activity for September 2020 and highlighted the following: • Cancer services – 14-day performance deteriorated sharply in August following a period of outstanding performance. However, this had shown a positive variation for September. Various ways to protect cancer services during the second wave and during winter have been discussed at the Cheshire and Mersey (C&M) Gold Command meetings • Referral to Treatment (RTT) – specific improvement plans around backlog issues had been discussed at FP&I and would be monitored going forward	

	• Bed Occupancy – feedback around the increase in bed occupancy at Ormskirk site would be presented at next month's FP&I Committee meeting. Mr Christian advised that the 52 week waiters would need to be viewed in context to the wider challenges of the pandemic and that these only made up 3% of the total C&M 52 week breaches. An update would be presented at FP&I as well as the Quality and Safety Committee meetings. A detailed work plan to support the clinical sustainability and recovery of the speciality gynaecology and ophthalmology services would also be presented at the Quality and Safety Committee meeting. **c) Financial Performance Report** Mrs Bottomley presented the Financial Performance report advising that, whilst the updated financial forecasts had been submitted, the finalised allocations were yet to be received. She advised that the Trust had spent 30% of its current Capital program and this underspend would be reviewed at the FP&I Committee next month along with a review of the three year financial program. Mr Masom observed that in his annual Chair's Self-Appraisal Report to NHSI/E, he had commented that performance in A&E had been positioned as Good. However, the rating for financial performance of the Trust remained 'red'. Despite this the report was a good reflection of the positive performance achieved during the current calendar year. **RESOLVED:** The Board **received** the Financial Performance Reports	
WORKFORCE		
TB178/20	**Workforce Reports** **a) Committee AAA Highlight Report** Mrs Gibson presented the highlight report from the Committee meeting held on 27 October 2020. It was noted that the completion rate of the Staff survey had increased since the report had been written. **b) Workforce Performance Report** Mrs Royds presented the Workforce Performance Report and highlighted the following: • Agency spend had shown a slight decline but was expected to increase due to the second wave of Covid-19 • The Doctors in Training (DIT) bank had been agreed and set up regionally. It was noted that whilst the rates had not been approved, the Trust had increased their rates for in-house trainees and were no longer seen as a significant outlier in this area • The increase in medical vacancy rates meant plans were in place for a strategy that mirrored nursing plans to be put in place. It was advised that support and governance of the DIT scheme would be provided by St Helens and Knowsley Hospital NHS Trust who were running the scheme. The trainees would be covered by the Trust's	

	policies and procedures. The Trust had been able to recruit an additional 30 international nurses through additional funding that had been made available. The total number of internal nurses recruited to date was 100 and, to ensure that these nurses were integrated, the Trust had applied for additional funding. It was noted that Health Education England had recently hosted a Webinar around global initiatives with recruitment. **RESOLVED:** The Board **received** the reports for information and assurance	
TB179/20	**Workforce Disability Equality Standard Report**	
	Mrs Royds presented the Workforce Disability Equality Standard report which provided an overview of the Trust's information and responses to the 10 indicators within the Workforce Disability Equality Standard (WDES). It was noted that before an action plan could be put in place the group would need to capture people's stories as this would highlight the focus areas. To this end Mrs Armstrong-Child and Dr Hankin have started a round of listening sessions. This has been seen as building on the paper that Ms Patten presented to the Board. Mr Masom requested that an update be provided to Board. **ACTION:** Mrs Armstrong-Child and Mr Hankin to provide an update to the Board on the progress and outcomes from listening sessions with the various Groups. **RESOLVED:** The Board **received** the Workforce Disability Equality Standard Report	CEO / MD
TB180/20	**Workforce Race Equality Standard Report**	
	Mrs Royds presented the Workforce Race Equality Standard report which provided an overview of the Trust's information and responses to the 9 indicators within the Workforce Disability Race Standard (WRES). **RESOLVED:** The Board **received** the Workforce Race Equality Standard Report	
RISK AND GOVERNANCE		
TB181/20	**Audit Committee AAA Highlight Report**	
	Mr Birrell presented the AAA Highlight Report from the Committee meeting held on 14 October 2020 advising that there were no key alerts to bring to the Board's attention. He advised that the Audit Committee would be reviewing controls at the committee meeting in January 2021. **RESOLVED:** The Board **received** the report	

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COMMITTEE MINUTES FOR INFORMATION		
TB182/20	**Committee Minutes**	
	The minutes of the following Committees were noted: a) Audit Committee b) Finance, Performance and Investment Committee c) Quality and Safety Committee d) Workforce Committee **RESOLVED:** The Board **noted** the Committee minutes	
CONCLUDING BUSINESS		
TB183/20	**Questions from Members of the Public**	
	Noting that no questions had been received from members of the public, Mr Masom encouraged members of the public to submit questions as this enabled the Board to respond to views and concerns of the patients and the local community to remain at the heart of Board discussions.	
TB184/20	**Message from the Board**	
	The Board agreed the messages to be circulated across the organisation.	
TB182/20	**Any Other Business**	
	In closing Mr Masom thanked Executive Team for Covid-19 presentation as well as all the work being done behind the scenes. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.55.	

Board Attendance 2020/21

Members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Neil Masom (Chair)	✓	✓	✓	✓		✓	✓	✓				
Trish Armstrong-Child	✓	✓	✓	✓		✓	✓	✓				
Jim Birrell	✓	✓	✓	✓		✓	✓	✓				
Yvonne Bottomley						✓	✓	✓				
David Bricknell	✓	✓	✓	✓		✓	✓	✓				
Bridget Lees	✓	✓	✓	✓		✓	✓	✓				
Steve Christian							✓	✓				
Julie Gorry	✓	✓	✓	✓		✓	✓	✓				
Terry Hankin	✓	✓	✓	✓		✓	✓	✓				
Therese Patten	✓	✓	✓	✓		✓						
Graham Pollard	✓	✓	✓	✓		✓	✓	✓				

Steve Shanahan	✓	✓	A	A		A	A	✓				
Gurpreet Singh	✓	✓	✓	✓		✓	✓	✓				
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	✓	✓		A	✓	✓				
Steve Christian	✓	✓	✓	✓		✓						
Jane Royds	✓	✓	✓	✓		✓	✓	✓				
Sharon Katema	✓	✓	✓	✓		✓	✓	✓				
✓ = In attendance A = Apologies												

DRAFT

Board of Directors (Part 1)

Matters Arising Action Log

Action Log updated 26 November 2020

NHS Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
TB149/20	07-Oct-20	**Board Assurance Framework (BAF)**	Mrs Armstrong-Child advised that the action to overlay the BAF with the last Audit Committee review is outstanding and Mr Regan has undertaken to complete this.	**DDQR&A**	03-Feb-21	03-Feb-21	**October Update:** Mr Regan to ensure that the next iteration of the BAF reflects recommendations from the last Internal Audit Review of the BAF.	**Green**
TB176/20	04-Nov-20	**Quality Improvement Programme**	Ms Lees advised that the key quality measures had started to come through the Perfect Ward dashboard but there were still areas outstanding. The first iteration of the Perfect Ward dashboard would be presented at the February meeting following the Quality and Safety Committee.	**DoN**	03-Feb-21	03-Feb-21	**November Update:** An overview of perfect ward to be presented to Board in February 2021.	**Green**
TB179/20	04-Nov-20	**Workforce Disability Equality Standard Report**	It was noted that before an action plan could be put in place the group would need to capture people's stories as this would highlight the focus areas. To this end Mrs Armstrong-Child and Dr Hankin have started a round of listening sessions. This has been seen as building on the paper that Ms Patten presented to the Board. Mr Masom requested that an update be provided to Board.	**CEO / MD**	02-Dec-20	07-Apr-21	**November Update:** Mrs Armstrong-Child and Mr Hankin to provide an update to the Board on the progress and outcomes from listening sessions with the various Groups.	**Green**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
TB068/20	06-May-20	**Use of Resources**	The Use of Resources self-assessment to be presented at the July Trust Board.	**DoF / CEO**	06-May-20	03-Jun-20	June Update: Included on agenda. Action completed July Update: To be presented first at July's FP&I Committee and then at Board in Sept. August Update: Not complete. Interim DoF to complete self-assessment for September FP&I Committee October Update: Use of Resources report and Action Plan submitted to September's FP&I Committee. To be submitted to November's Board **November Update**: Use of Resources Report and Action Plan presented at Board. Action Completed	**Blue**
TB088/20	03-Jun-20	**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.	**IDoF**	01-Jul-20	01-Jul-20	**July Update :** The work to address this action is progressing. An update will be presented at the September meeting **September Update:** Update will be provided at FP&I in September and to Board in October. **October Update**: Update will be provided at November Board **November Update:** Report presented at October's F,P&I Committee. The Committee members were satisfied that the paper answered the questions that had been posed by the Board in June 2020 and was assured both that the appropriate governance processes had been followed and that data was being consistently reported. Action Completed	**Blue**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB191/20**	**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 Chairs' Meetings
- Acute Sustainability Strategy ('Shaping Care Together')
- Staff flu campaign
- Covid19 Update
- Nurse recruitment
- Annual memorial service
- Charitable Funds

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

1. Introduction

1.1 The Trust has continued to see an increase in Covid-19 admissions which continues to put strain on staff in the Trust and I would like to extend my personal thanks to everyone's efforts in rising to the challenge of this second wave.

1.2 Since the last Board meeting, the Trust has been recognised with a number of awards including the Children's Diabetes Team, led by Prof May Ng who won the Excellence in Health Care Award (North West) of the NHS Parliamentary Awards 2020, and the Critical Care Team who won the Emergency and Critical Care team award in the Nursing Times Awards 2020.

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

2.1 The NHSE/I North West Regional Director and his team, have continued to deliver fortnightly briefings to all NHS trust chairs within the region during the pandemic.

2.2 The last briefings on 22 November focused on:
a) Increased staff testing
b) Vaccinations
c) Mental Health

3. Shaping Care Together

The Shaping Care together has now moved into Communications and Engagement with stakeholder phase. The formal launch is expected to commence in December.

4. Staff flu campaign

4.1 Our annual flu campaign had the usual fantastic response from staff supported by the hard work of the Health and Wellbeing Team.

4.2 As of 23 November, more than four-out-of-five (81%) of health care workers had been vaccinated and 70% of the total workforce protected. Within those totals 94% and 93% of doctors and allied health professionals, respectively, had had their jab.

4.3 This year's flu campaign is now ending as we prepare for the national Covid-19 vaccination programme. We also need to ensure there is a minimum seven-day gap between flu and the start of a potential Covid vaccination programme.

5. Covid update

5.1 After a steep rise in admissions of patients with Covid-19 infection, we began to see a steady fall throughout November as national restrictions took effect and prevalence of the disease fell in the local population.

5.2 We have continued to maintain our programme of planned care work. However, the impact of admissions of patients with Covid infection combined with the usual winter pressures on Trust beds presents an ongoing challenge.

5.3 In line with national guidance, asymptomatic patient-facing staff began regular testing for Covid-19 on 23 November. This will support us preventing patients, and other staff, becoming infected by staff who are not symptomatic

6. Nurse recruitment

6.1 We welcomed our latest six nurse recruits from India in November, bringing to 16 those who have arrived so far. We expect a further 16 in January and plan to have 52 nurses as part of our recruitment campaign on the sub-continent by Easter.

7. Annual memorial service

7.1 The Trust annual memorial service was broadcast online this year because of Covid restriction.

7.2 Every year the chaplaincy and spiritual care service holds a memorial event for the remembrance of loved ones – but that's not possible this year because of social distancing for Covid-19.

7.3 Instead the hospital chaplains, Consultant in Palliative Medicine Dr Karen Groves and Consultant Clinical Health Psychologist Dr Dominic Bray, supported by a choir and professional musicians, reflected on coping with grief in a pandemic in an online broadcast, A Time to Remember.

7.4 The service was broadcast on Sunday 1 November and has so far been seen by nearly 500 people.

7.5 The annual baby memorial service will follow a similar format. It will be available from 6.30pm on Wednesday 9 December on the Trust's YouTube channel.

8. Charitable Funds

8.1 The charity appeal to support staff, patients and volunteers through the Covid-19 pandemic has continued to be supported in a fantastic way by the community with more than £116,000 having been raised since we launched the appeal in April.

8.2 We continue to be grateful to everyone who is raising money for Southport and Ormskirk Hospital Charity. We also continue to work with NHS Charities Together who are disbursing the tens of millions of pounds raised by the public this year.

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 December 2020**
Agenda Item	**TB192/20**	**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 some high-level updates on activities within the Trust since the previous meeting of the Board of Directors in November. These include:

- Awards and Recognition
- News and Developments
- Trust News
- Reportable Issues Log
- Media Coverage
- Risk Register and Board Assurance Framework

Recommendation

The Board is asked to receive the report for information.

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:**
Trish Armstrong-Child, CEO	Trish Armstrong-Child, CEO

Southport and Ormskirk Hospital NHS Trust

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 SAS Awards Results - HEE NW SAS Doctors presentation evening:

Congratulations to our Specialty and Associate Specialists, or SAS, doctors, who swept the board at a virtual awards event hosted by Health Education England. They were winners in five categories and highly commended in four. More than 100 nominations were received from 17 NHS trusts across the North West. SAS doctors are the backbone of our medical workforce and the judges' comments were exceptionally positive.

Category	Winner	Highly Commended
Clinical Excellence Award	Lesley Kaye	Vidyanathan Subramanian
Educator Award		Krishnan Gokul
Quality Improvement Award	Jyontindra Nirmal	
Innovation Award	Anthony Asakpa	
CESR Achievement Award	Peter Gledhill	
Leadership Award		Chetan Sangani
Lifetime Achievement Award	Vidyanathan Subramanian	Lesley Kaye

1.2 Critical Care wins Nursing Times award

The Critical Care team emerged victorious in the Emergency and Critical Care category of the prestigious Nursing Times Awards 2020. They were recognised for their innovative ways of caring during the Covid-19 pandemic, including a virtual video tour to alleviate relatives' fear of the unknown during restrictions on visiting. Huge congratulations to them.

1.3 Independent Sexual Violence Advisor wins Nursing Times award

Well done too in the Nursing Times awards to Faye Speed, our Independent Sexual Violence Advisor, who won the Integrated Approaches to Care Award as part of the Independent Sexual Violence Advisory Service. It aims to improve support available to victims of sexual abuse/violence, who present in health settings. By providing a consistent, timely approach, raising awareness amongst the health workforce, so that victims of sexual violence receive quality, compassionate and safe responses.

1.4 NHS Parliamentary Awards

Congratulations too to Prof May Ng and the children's diabetes team at Ormskirk hospital who were the North West winners in the Excellence in Health Care Award category of the NHS

Parliamentary Awards 2020. This award was submitted and supported by Rosie Cooper, MP for West Lancashire.

Their innovative and imaginative approach to care has hugely improved national diabetes clinical outcomes for children and young people. It has included embracing diabetes technology and social media for patient engagement; routinely using telemedicine clinics since 2015; holding family diabetes fun day events and evening structured family education sessions; establishing a children's Diabetes Geeks Club while embracing well-being and solution-focused approaches into routine diabetes care.

They now go head-to-head with other winning regions ahead of next year's award ceremony.

1.5 Time to Shine Awards 2020

Our annual staff awards will be broadcast and presented in an online broadcast this year after Covid-19 stopped us holding are usual awards ceremony. The format means that friends and family staff will also be able to watch the event on Thursday 17 December at 6.30pm.

The shortlisted nominees are:

Clinical Team of the Year (clinical)	Oasis Ward Neonatal Unit Critical Care and Critical Care Outreach teams
Behind the Scenes Award	Domestics and Catering teams Health and Wellbeing team Cancer Services team IT team
People's Health Hero Award	Rachel Chidley Keran Carter Sara Gara
Everyday Excellence Award	Phil Capper Mary Stead Kathy Hickson
Improvement Award	Home First Therapy team Neonatal Unit Paediatric Education Centre
Clinical Mentor of the Year	Sarah Ralph Rachelle Alty Sarah O'Connor
Compassion in Action Award	Elizabeth Masterton Children's Community Nursing Outreach team A&E Therapy team
Learner of the Year Award	Lauren Jay Smith

	Sarah Currie Diane Sutton
Volunteer of the Year Award	Dorothy Webster Pharmacy Volunteers Craig Alty (for charity fund raising) Southport volunteers Covid team
Thanks a Bunch Award	Andrew Robins Lisa Stone Linda Lewis, and Health and Wellbeing team

1.6 SO Proud Awards

Well done to Nicola Ivanovic, Joanne Russell, Kathy Hickson, Debbie Bulloch, David Patterson and Rachel Chidley who received SO Proud badges and certificates this month. The awards are made to staff who have "gone the extra mile" on the recommendation of colleagues. They were presented with So Proud certificates and pin badges.

1.7 Thanks a Bunch awards

Over the summer we asked staff to tell us who should be recognised in our Thanks a Bunch awards for going the extra mile during the COVID. Last month, we recognised:

- Lynn Sugden (Medical Day Unit)
- Pain team

2 News and Developments

2.1 NHS111 First launched

We started receiving our first patients last month when we joined other north Mersey hospitals launching NHS111 First.

People needing urgent NHS care were reminded to contact NHS 111 before attending an emergency department (ED).

People with life-threatening conditions that need emergency attention should still call 999. Likewise, if the condition is not serious then they should still seek advice from their pharmacy or make an appointment with their GP.

NHS 111 will direct people to the most appropriate health service which may include a walk-in centre, GP practice, pharmacy or hospital. If patients are assessed as needing to attend an ED, they will be given a booked time slot.

Emergency departments treat patients in order of clinical priority. Patients who walk into ED without contacting NHS 111 First will still be seen, but those with appointments from NHS 111 will

be prioritised unless those patients have a greater clinical need. This means that contacting NHS111 First is the quickest way for patients to get the care they need

2.2 Car parking

Blue badge holders will be able to park for free at Southport and Ormskirk hospitals from 1 December 2020 when parking charges come back into force. Fees were suspended for all visitors at the height of the first wave of the Covid-19 pandemic in March.

Parking continues to be free for:

- Relatives of patients at the end of life
- Cancer patients
- Parents of neonatal babies
- Parents of children staying overnight.

The Trust has made a significant investment over the summer installing an automatic number plate recognition car parking system to make visiting our hospitals much easier with payment available by card or cash. Because this system uses number plate recognition technology, it means no lost or damaged tickets with the delays and frustration that can cause.

Hospital parking fees remain unchanged. Our staff continue to park for free until further notice.

3 Trust News

3.1 COVID19

Regular testing for asymptomatic patient facing staff using lateral flow kits has gone live and the distribution of 2,200 kits to staff commenced across the Trust on Tuesday 24th November. This includes testing of our temporary workforce (NHSP and agency) and students on placement. Staff self-administer a test twice weekly for next 12 weeks and the results are reported electronically to the Trust

The Trust is working closely with the regional NHSE/I team to prepare for the mass vaccination roll out. The indicative date is 1st December, however, at the time of writing this report MHRA approval is still awaited. The organisation will be designated as a site to deliver the vaccination programme to staff and this may extend beyond our own employees The plans continue to evolve at the time of writing but GOLD has an overview of all our preparations and there has been a significant focus this month on getting our flu vaccination programme expediated to enable staff to be able to receive the vaccination once ready. As of Monday 23rd December, the Trust was reporting an 81% staff uptake of the flu vaccination

3.2 Shaping Care Together

The Shaping Care Together Programme Board continues to meet. The communication and engagement programme is slightly behind at this point, however, the staff engagement element is already underway.

3.3 NHSE/I Regulatory Meetings and Visits

The Trust continue to be represented at the weekly NHSE/I COVID 19 briefings

We have been advised that our Head of Hospital Inspector for the CQC has recently changed and Karen Knapton will be taking up post. We look forward to working with her.

4 Reportable Issues Log

Issues occurring between 27/10/2020 to 20/11/2020

4.1 Serious Incidents and Never events
No serious incidents or never events reported

4.2 Level Four and Five Complaints

- One level five complaint relating to treatment.
- Level 4 Complaints – 5

All 5 complaints are within Urgent Care and are being investigated in line with the Trusts complaints policy

4.3 Regulation 28 Reports
None to report.

5 Media Coverage

People in Merseyside told to dial 111 before turning up at A&E (Liverpool Echo 18/11/20 https://www.liverpoolecho.co.uk/news/liverpool-news/people-merseyside-told-dial-111-19299767)

Nursing Times Awards 2020 sees Southport Hospital win Critical Care Award (Stand Up for Southport 18/11/20 https://standupforsouthport.com/nursing-times-awards-2020-sees-southport-hospital-win-critical-care-award/)

Hospital charity pandemic appeal reaches £116,495 (Champion newspapers, 4/11/20)

We tried to get the full picture of the coronavirus situation in Liverpool City Region hospitals (Liverpool Echo 25/10/20 https://www.liverpoolecho.co.uk/news/liverpool-news/tried-full-picture-coronavirus-situation-19157048)

6 Risk Register and Board Assurance Framework

No new risks to report.

Trish Armstrong-Child

Chief Executive
Date 25 November 2020

Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB193/20**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Andrew Chalmers, Consultant Nurse/Deputy Director - Infection Prevention & Control		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

The purpose of this report is to provide the Board with an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Assurance Framework.

Executive Summary

The updated IPC BAF was reported to the Board last month in November 2020. The latest version shows that we are compliant with the vast majority of areas and we have systems and processes in place to manage and monitor IPC guidance and identify risks.

Since the last report two further areas have been BRAG rated as Blue (completed)

- Screening for other infections such as MRSA,CDIF etc (Page 9)
- Face coverings are used by all outpatients and visitors (Page18)

IPC audits and mandatory training continues to be monitored, latest data indicates:

- Hand Hygiene Audits - Trust compliance End Oct 2020 (**99.7%)**
- PPE Compliance Audits - Trust compliance End Oct 2020 **(97.2%)**
- IPC Mandatory Training - Compliance – Level 1 Oct 20 **(93.19%)**

Key focus areas from this version of the IPC BAF remain unchanged are in relation to:

- Bed spacing – It has been agreed to add additional screens between patient's beds. Implementation is expected to commence w/c 23.11.20
- Enhanced Donning & Doffing training is available for all staff in addition to Level 1 and 2 IPC training. Training records are currently being transferred from local paper records onto ESR. As of 23.11.2020, a total of 563 staff from a number of disciplines have been recorded on ESR.
- Due to the changing availability of FFP3 respirators staff are being reassessed (fit tested) for respirators currently available, 289/400 fitted on reusable masks. Completion date anticipated 4.12.20. In addition, Information Technology Team (IT) have designed database for recording of results live 20.11.20 – 2,776 results now live (includes all test results).

Mitigating Actions have been developed for potential gaps in assurance, details of which are included in the template. This framework will be regularly revisited to monitor progress and mitigation regarding gaps and compliance against any new or amended guidance. Updates will continue to be presented to IPC Assurance Group, Quality & Safety Committee and Trust Board.

Recommendation

The Board is asked to receive and note progress in relation to measures within the Infection Prevention and Control (IPC) Board Assurance Framework.

Previously Considered By:

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

Southport and Ormskirk Hospital NHS Trust

☐ **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:**
Andrew Chalmers | Jo Simpson	Bridget Lees

Publications approval reference: 001559

Infection prevention and control board assurance framework

15 October 2020, Version 1.4

Updates since previous versions are highlighted in **bold**

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	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
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 • ED (Adults & Children's) also Red and Green areas • Out patients – patient temperatures monitored at front door • Maternity Audits to be completed bi-monthly	None identified	N/A		
• 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 cohorted may be in incubation, therefore risk of infecting other patients	Risk assessments in place. Patients moved accordingly.		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Patients are swabbed prior to discharge or transfer and status is documented in discharge summary • All patients discharged are given relevant information	None identified	N/A		
• monitoring of IPC practices, ensuring resources are in place to	• Hand Hygiene Audits (Trust compliance End Oct 2020 **(99.7%)** • PPE Compliance Audits for End Oct-	Small improvements needed to achieve 100% compliance consistently with hand hygiene and	• Ward Walking by Quality Matrons and IPC Team • Weekly Perfect Ward audits		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
enable compliance with IPC practice	20 **(97.2%)**	PPE requirements.	commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards		
• monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• As above - PPE Compliance Audits for End Oct-20 **(97.2%)**	Small improvements needed to achieve 100% compliance consistently with PPE requirements.	• Establishing role of Covid Champions – part of their role will be monitoring PPE compliance (Dec 20) • Staff redeployed to IPC Team to support Ward Walking and promoting PPE compliance • Ward Walking by Quality Matrons and IPC Team • Weekly Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards		
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	1. Staff screening in place – wards with increased cases of Covid are screened and rescreened. 2. 500 staff enrolled in Siren Study (screening every 2 weeks) 3. Asymptomatic screening for all patient facing staff (End of Oct 20 2% prevalence and 1422 staff tested) 4. Lateral flow testing for all patient facing staff to begin w/c 23.11.20. 5. Staff with symptoms are told to self-isolate and screening is arranged via Health & Wellbeing Team	None identified	N/A		
• training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be	• IPC Mandatory Training - Compliance – Level 1 Oct 20 (**93.19%) and Level 2 (77.9%)** • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid	None identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
included in all staff Induction and mandatory training	• Additional Don and doffing training in place ward based • Online You Tube training • E learning Package due to be launched to support face to face training for level 2				
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Communications briefs (over 20 key messages about wearing face masks, hand hygiene and social distancing have been included in Trust News since 11 Sept 20) • Ward Walking in place to remind staff re PPE compliance and provide training as needed • Matron of the day on site 7 days a week • IPC Team presence on site 7 days a week • All corporate staff required to wear face masks at desks in Corporate Management Office (CMO)	None identified	N/A		
• 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	• Enhanced Donning & Doffing training for all staff in addition to Level 1 and 2 IPC training • As of 23.11.2020, a total of 563 staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. Work is ongoing to continuously update the central training records from local records, as local areas complete their training sessions. • Due to the changing availability of FFP3 respirators staff are being reassessed (fit tested) for respirators currently available.	Training records in relation to Donning & Doffing training is currently paper based	Records are held locally and process underway to record training records electronically on ESR to enhance the reporting of IPC training, which will include sub-sections of donning and doffing Enhance fit testing overview to allow procurement to be targeted to equipment already tested for. Establishing role of Covid Champions – part of their role will be monitoring PPE compliance (Dec 20).		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
	○ 289/400 fitted on reusable masks. Completion date anticipated 4.12.20. ○ IT designed database for recording of results live 20.11.20 – 2,776 results now live (includes all test results). • Comms circulated to staff if / when guidance changes. • Staff redeployed to IPC Team to support Ward Walking and promoting PPE compliance • IPC Operational meetings in place • Since June 2020 (when all staff were required to wear face masks) 'wearing face mask correctly' posters has been provided through Trust news and posters around hospital • All corporate staff required to wear face masks at desks in CMO and these are provided by the Trust at all access points with hand gel and signs indicating how to put the masks on safely.				
• 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 IPC Operational Group, clinical reference group (CRG), CBU & Support Cells or Bronze, Silver and Gold to wards, clinical and corporate areas. • Daily infection control meetings in place 7/7 chaired by the DIPC	None identified	N/A		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are	• As above, risks in relation to Covid-19 (PPE, equipment, service moves and staffing). Reviewed by IPC group, Gold command and Clinical Reference Group (CRG).	None identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
highlighted	• Also discussed in CBU and support cells and Business with Covid programme 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, ETM, QSC (monthly) and Board (monthly)	None identified	N/A		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Work process in place for non covid infections which is linked into Medway and reported through the IPC epidemiological IT program. • Swabbing and screening processes in place for other infections such as MRSA, CDIFF etc. • Risk assessments in place, all clinical areas are zones into red or green. • Monthly IPC report in place • Quality Priority (including IPC) monthly reports submitted to QSC and Board.	None identified	N/A		
• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• Deputy DIPC / IPC Team review and confirms the data produced by BI Team which is then ratified by the DIPC (in absence will be CEO) 7 days a week • Daily IPC meetiings chaired by the DIPC 7/7 • Reported to GOLD as part of daily update to CEO (chair) Execs and senior team • Reported on the daily Sitrep in the Trust	None identified	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	• Reported through Outbreak meetings to Silver and Gold command structures then to Board • Reported via Quality & Safety Committee. • Outbreak and Enhanced Operational IPC meetings in place • COVID Updates and Outbreaks reported to Trust Board	None Identified	N/A	New Measure	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
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 Mandatory Training - Compliance – Level 1 Oct 20 (**93.19%) and Level 2 (77.9%)** • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • You Tube video remains on line and latest guidance available on intranet and in clinical areas. • Ward Walking by Quality Matrons and IPC Team to provide advice and support • Weekly Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards	None Identified	N/A		
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or	• Additional investment in domestic cleaning teams. • Enhanced cleaning teams already in place for high risk areas. • Specific training has been provided for cleaning staff including enhanced donning and doffing and fit testing.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
cohort areas.	• Training records for Domestics (including fit test) and annual staff competencies are held centrally.				
• 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. • Additional investment in domestic cleaning teams. • Enhanced cleaning teams already in place for high risk areas. • Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x across 24hrs • Daily Assurance reporting regarding cleaning standards introduced on daily sitrep and reported to Gold Nov 20 including: ○ Cleaning hours have been met ○ Numbers of additional cleaning hours undertaken by the task team ○ Average time to commence task team request	Central overview of cleaning compliance.	• New sitrep in place monitoring sign off of cleaning schedules • Plans for development of a rapid response team to bolster the service for the winter period.		
• 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 across 24hrs	Central overview of cleaning compliance.	• New sitrep in place monitoring sign off of cleaning schedules		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• 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 • Discussed at IPC Assurance meeting and agreed to continue to use Tristel throughout the Trust. This will continue to be reviewed	None Identified	N/A		
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance:'	• Domestic Staff – instruction included in cleaning procedures. Communications reminder to be shared with clinical and corporate staff • Staff comms circulated in Trust News (October 2020) regarding disinfectant products to make sure we allow to air dry for at least 60 secs.	None Identified	N/A		
• 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 across 24hrs • New sitrep in place monitoring sign off of cleaning schedules	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Multi use spaces and hot desking - responsibility of user to wipe down before and after use. • Reminder on Covid Ward Standards and promoted via Trust News and in addition reviews by ward walkers.	None Identified	N/A		
• 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 across 24hrs	Central overview of cleaning compliance.	New sitrep in place monitoring sign off of cleaning schedules		
• 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	None Identified	N/A		
• single use items are used where possible and according to Single Use Policy	• Yes, Single Use Policy is included in IPC Manual	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Yes, all through HSDU. • Beds and equipment is wiped down with disinfectants at ward level • Air mattresses are bagged by Medical Equipment Library (MEL) staff and outsourced for cleaning and returning. • MEL cleans pumps and other equipment with clinell wipes	None Identified	N/A		
• ensure cleaning standards and frequencies are monitored in nonclinical areas with actions in place to resolve issues in maintaining a clean environment	• Domestic Team Leaders monitor non-clinical areas at a reduced frequency. • Corridors and public areas – Trust completing enhanced cleaning overnight. To be monitored via sitrep • (please see previous entry re decontamination sitrep)	None Identified	N/A		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Trust has a filtered balanced air ventilation system with supply and extract in all patient areas. In addition to this there is natural ventilation eg windows	None Identified	N/A	New Measure	
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	• Discussed at IPC Assurance meeting and agreed to continue to use Tristel throughout the Trust. This will continue to be reviewed.	None Identified	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
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. • The new adult guidelines were approved at the Antimicrobial Stewardship Committee. Comments were invited from the rest of the trust and then approved by the Drugs and Therapeutics Committee. The new guidelines were published on 5th August via the new Microguide app with trust emails and junior doctor induction presentations alerting staff to the change. • Antimicrobial stewardship committee continue to meet, last on 16th Sep 2020. • The most recent antibiotic audit (July 20) provided assurance - indication for antibiotics were documented in 97% of patients reviewed and a review was done at 72 hours for 94%. Next audit due	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• 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)	None Identified	N/A		
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					
Systems and processes are in place to ensure:					
• implementation of national guidance on visiting patients in a care setting	• We are adhering to regional Cheshire & Merseyside guidance in relation to visiting. Exemptions are in place for End of Life patients, birthing partners in maternity. Parents or Carers in paediatrics and partners of women experiencing pregnancy loss	None Identified	N/A		
• 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	• Risks assessments in place and clinical areas are Zoned as Red and Green	None Identified	N/A		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Yes available on website and recorded message on Trust telephone. • Adequacy checked by Equalities Lead	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• 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 • Discharge coordinators and planners also discuss and verify during discharge planning.	None Identified	N/A		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Risk assessments in place, all clinical areas are zoned into red or green. • PPE posters in place in corridors and near entrances to wards and within wards • Ward walkers to regularly check visibility. • New signage ordered Nov 20 to refresh and rebrand to minimise human factors and fatigue	None Identified	Currently refreshing the signage	New Measure	
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					
Systems and processes are in place to ensure:					
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	• (1) Emergency admissions – patients assessed for symptoms and also swabbed • (2) Planned admissions – patients swabbed prior to admission and provided with guidance and patients asked to phone in if they are symptomatic. • (3) Outpatients – Move to virtual clinics where possible, if need to attend in person, patients are provided with written information regarding signs and symptoms of Covid and asked to rearrange if symptomatic. In addition temperature	None Identified	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
	checks and symptom checks completed on entrance to clinics. • 3 day post admission testing to commence w/c 23.11.20 including a Covid-19 testing passport to be kept in the patient's record, a copy can be shared with patient on discharge.				
• 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	None Identified	N/A		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Algorithm in place for assessing low risk, possible and probable patients as they enter ED and outpatient appointments. Patients are then allocated an appropriate pathway	None Identified	N/A	New Measure	
• face coverings are used by all outpatients and visitors	• Masks are provided for all patients and staff as they come through front doors.	Some patients may not be able to tolerate masks	N/A	New Measure	
• staff are aware of agreed template for triage questions to ask	• Yes, set of questions identified and asked at ED and Outpatients	None Identified	Monitor compliance before turning blue	New Measure	
• face masks are available for patients with respiratory symptom	• Yes, all patients are encouraged to wear facemasks and provided with written guidance.	Some patients may not be able to tolerate masks	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Yes, all patients are encouraged to wear facemasks and provided with written guidance.	None Identified	N/A	New Measure	
• Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Patients are segregated and in addition we have screens for reception staff and volunteers at front door • Where able to Trust is increasing the distance between patient beds on wards and extended space between chairs in waiting areas. • Trust also reviewing the use of screens where social distancing is restricted	Potentially areas where patient social distancing will be less than 2 meters due to the environment in the older estate accommodating most wards	To mitigate we are providing face masks, reducing clutter, promoting the use of pulled privacy curtains between bed spaces and exploring the use of screens as a physical barrier between patients Options appraisal being developed as to further opportunities to enhance Readirooms being used where needs are identified. It has been agreed to add additional screens between patient's beds. Implementation is expected to commence w/c 23.11.20	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• We isolate patients with new onset symptoms and investigate potential contacts • Labs report cases and PHE instigate track and trace	Lack of side rooms to isolate	Readirooms are used to isolate when side rooms not available Patient flow model has been updated to enable patients to stay in their ward of admission until they have had 2 negative swabs		
• 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. Readirooms are used to isolate when side rooms not available IPC Team to liaise with Patient Flow Team and Business Intelligence Team		
• 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
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					
Systems and processes are in place to ensure:					
• separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• One way system (corridors and stairways) in place across Trust and designated lifts for Covid and non Covid patients.	None Identified	N/A	New Measure	
• 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 Mandatory Training - Compliance – Level 1 Oct 20 (**93.19%) and Level 2 (77.9%)** • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • Ward Walking by Quality Matrons and IPC Team	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)

• 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	• Donning and Doffing training provided at ward level.
	  ○ As of 23.11.2020, a total of 563 staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE.
	  ○ Work is ongoing to continuously update the central training records from local records, as local areas complete their training sessions.
	• Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit.
	  ○ 289/400 fitted on reusable masks. Completion date anticipated 4.12.20.
	  ○ IT designed database for recording of results live 20.11.20 – 2,776 results now live (includes all test results).
	• You Tube video remains on line and latest guidance available on intranet and in clinical areas
	• Weekly Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards
		Training records in relation to Donning & Doffing training is currently paper based.
		
		Given the move to automated fit testing and reassessments, the process needs to be embedded to enhance opportunities for procurement to provide the equipment already tested for, specific to the areas.
			Records are held locally and process underway to record training records electronically on ESR to enhance the reporting of IPC training, which will include sub-sections of donning and doffing
			
			Enhance fit testing overview centrally and locally to allow procurement to be targeted to areas where equipment already tested for.
			
			A new web based in house built system has been developed to record and report fit testing status for all staff, this will be accessible at ward and department level.		

• a record of staff training is maintained	• IPC Mandatory Training - Compliance – Level 1 Oct 20 (**93.19%) and Level 2 (77.9%)** • Donning and Doffing training provided at ward level (all staff asked to verify completion, compliance to be monitored via ESR.	Training records in relation to Donning & Doffing training is currently paper based	Records are held locally and process underway to record training records electronically on ESR to enhance the reporting of IPC training, which will include sub-sections of donning and doffing.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
	○ As of 23.11.2020, a total of 563 staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. ○ Work is ongoing to continuously update the central training records from local records, as local areas complete their training sessions. • Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available. ○ 289/400 fitted on reusable masks. Completion date anticipated 4.12.20. ○ IT designed database for recording of results live 20.11.20 – 2,776 results now live (includes all test results).		A new web based in house built system has been developed to record and report fit testing status for all staff, this will be accessable at ward and department level.		
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS alert is properly monitored and managed	• Existing CAS alert process is still in place and escalated via Silver Command or SOS cell • The original April guidance was withdrawn on 10/09/20 as PPE stocks had increased.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Any incidents are recorded in Datix and investigated accordingly • Communications to staff to remind them to Datix any issues. Any incident responses are managed daily if required and SIRG if applicable and with Health & Safety	None Identified	N/A		
• adherence to PHE national guidance on the use of PPE is regularly audited	• IPC Audits in place, any issues identified are raised at the time with individuals. Any patterns / themes and trends would determine what additional training is needed going forward. • Ward Walking by Quality Matrons and IPC Team • If individuals repeatedly fail to adhere to Trust standards, this will be escalated. • Weekly Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards • (Trust compliance End Oct 2020 **(99.7%)** • PPE Compliance Audits for End Oct-20 **(97.2%)**	None Identified	N/A		
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene	• Hand Hygiene facilities in all clinical areas with automated soap dispensers and paper towel dispensers • Instructional posters adjacent to each hand-wash basin.			New measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
facilities including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	• All patients are asked to wear face masks, all staff are required to wear facemasks and all visitors and patients attending outpatient clinics are asked to wear face coverings • We have segregation in place to minimise risks to patients and in addition we have screens for reception staff and volunteers. • Where able to Trust is increasing the distance between patient beds on wards and extended space between chairs in waiting areas. • Trust also reviewing the use of screens where social distancing is restricted • Posters visible promoting social distancing and wearing of face masks • New sitrep in place monitoring sign off of cleaning schedules	Potentially areas where patient social distancing will be less than 2 meters	To mitigate we are providing face masks, reducing clutter, promoting the use of pulled privacy curtains between bed spaces and exploring the use of screens as a physical barrier between patients		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Process in place for hand hygiene audits and standard IPC observations. • Hand Hygiene Audits (Trust compliance End Oct 2020 **(99.7%)**	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• 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 located close to the sink but beyond the risk of splash contamination, as per national guidance	• All hand dryers have been deactivated and paper towel dispensers and waste bins are in place in all areas	None Identified	N/A		
• 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	None Identified	N/A		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Yes, this has been communicated to staff through communications.	None Identified	N/A		
• 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 •	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• Daily sitreps in place produced by BI Team in conjunction with IPC and staff health and wellbeing. Circulated to all board members. • If outbreak detected IPC measures are put in place and reported via Outbreak meeting to Silver and Gold command structures then to Board	None Identified	N/A	New Measure	
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• All positive cases are reported to the consultant microbiologist and IPC Team who review cases and determine appropriate action based on NHSE/I guidelines. • COVID-19 RCA in place for infections where criteria is met. • DIPC signs off all cases. • Outbreak meetings are convened when criteria is met.	None Identified	N/A	New Measure	
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	• IPC Policy in place and IPC manual available for guidance. • Covid-19 policy also in place	None Identified	N/A	New Measure	
7. Provide or secure adequate isolation facilities					
Systems and processes are in place to ensure:					
• restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals,	• COVID-19 pathways in place. On admission patients are assigned to a covid zone (red, amber green). Green areas are on the Ormskirk site, amber areas are paediatrics, maternity and emergency surgery and medicine wards. Red areas are	None Identified	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
visitors or staff	• wards with covid positive or strongly suspected patients primarily on the Southport site. • Staff are assigned individual wards and on the whole are kept within that ward unless there are extenuating circumstances				
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk area	• All wards are locked down as clear signage indicating Covid zone status and PPE requirements	None Identified	N/A	New Measure	
• 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.		
• 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	• Escalation plan is to cohort in larger areas to support patients and maintain distancing	Limited availability of Side Rooms	Bed base reviewed by Bed Manager, Clinell Ready Rooms are available where possible		
• 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
8. Secure adequate access to laboratory support as appropriate					
There are systems and processes in place to ensure:					
• ensure screens taken on admission given priority and reported within 24hrs	• Patient tests are processed by St Helen's and Knowsley NHS Trust who provide audit information on processing times.	None Identified	N/A	New Measure	
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Audits are undertaken by St Helen's and Knowsley NHS Trust and reported to laboratory contracting group	None Identified	N/A	New Measure	
• testing is undertaken by competent and trained individuals	• Yes, testing undertaken by labs at St Helen's and Knowsley NHS Trust, comply with all clear national guidance	None Identified	N/A		
• 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 • All patient and staff testing (including asymptomatic swabbing is completed promptly in line with national guidance	None Identified	N/A		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• Audits are undertaken by St Helen's and Knowsley NHS Trust and performance monitored and reported to laboratory contracting group • Also, monitored via patient dashboard by the patient flow team.	None Identified	N/A	New Measure	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• screening for other potential infections takes place	• Yes, also screen for flu, MRSA, Strep, Legionella	None Identified	N/A		
9. Have and adhere to policies designed for the individual's care and provider organizations that will help to prevent and control infections					
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	None Identified	N/A		
• 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 clinical reference group (CRG), Silver (now replaced by operational cells) and Gold, changes / amendments to policy and SOPs are cascaded via Comms Team and by IPC Team	None Identified	N/A		
• 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. Capital scheme regarding storage will commence by December 2020 and will be completed by March 2021	All waste from clinical areas at Southport is currently classed as infectious therefore no issue with mixing of clinical waste		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• PPE stock is appropriately stored and accessible to staff who require it	• Yes, stored in dry, cool store with appropriate security • Monitored via Procurement Sitrep.	None Identified	N/A		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
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 assessments developed to support managers and staff in mitigating risks. Risk assessments are regularly reviewed if changes to environment or staffs' health status • Risk assessments reviewed and updated in line with government guidance and advice • 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 for staff Health & Wellbeing • To date the staff Health & Wellbeing have provided specific advice to over	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
	3,000 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:** 33 departments in Ormskirk 35 departments in Southport. • Our OD team is providing 'coaching' face to face and remotely. • Our OD team are working with teams who need support. • Our OD team are keeping in contact with our new starters				
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	• Risk assessments have been completed and are regularly reviewed. • The risk assessment template has been updated to reflect the most up to date government guidance and advice	None Identified	N/A	New Measures	
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained **and held**	• FFP3 respirators currently in use in addition powered air purifying respirator (PAPR) respirators are also being used; SOP in place regarding use and maintenance. • Trust identified reusable respirators	Given the move to automated fit testing and reassessments, the process needs to be embedded to enhance opportunities for procurement to provide the equipment already tested for, specific to the areas.	Enhance fit testing overview centrally and locally to allow procurement to be targeted to areas where equipment already tested for.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
centrally	that can be used and where they can be located. 700 half face reusable respirators have been procured • Staff are being identified who will use the half face respirators and are being fit tested. • Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available. • Process in place for documenting Fit Testing centrally this also needs to be available locally on wards and clinical areas. Plans in place to have information available regarding who has been tested and on what respirator on wards and clinical areas.				
• staff who carry out fit test training are trained and competent to do so	• Trainers have been trained by the IPC Team and external trainers. The list of trainers is held centrally by the BI Team and will be available at ward and clinical area level.	None Identified	N/A	New Measures	
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available. • Staff are being identified who will use the half face respirators and are being fit tested.	Given the move to automated fit testing and reassessments, the process needs to be embedded to enhance opportunities for procurement to provide the equipment already tested for, specific to the areas.	Enhance fit testing overview centrally and locally to allow procurement to be targeted to areas where equipment already tested for.	New Measures	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• a record of the fit test and result is given to and kept by the trainee and centrally within the organization	• The trainee receives a document including date of testing / training and type of respirator • Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available.	Given the move to automated fit testing and reassessments, the process needs to be embedded to enhance opportunities for procurement to provide the equipment already tested for, specific to the areas.	Enhance fit testing overview centrally and locally to allow procurement to be targeted to areas where equipment already tested for.	New Measures	
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• The trainee receives a document including date of testing / training and type of respirator • To date any member of staff who has failed a fit test has been given access to a powered air purifying respirator (PAPR)	None Identified	N/A	New Measures	
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• To date any member of staff who has failed a fit test has been given access to a powered air purifying respirator (PAPR) or staff are not rostered to work if there isn't a member of staff who has been successfully tested on duty.	None Identified	N/A	New Measures	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• To date no staff have needed to be redeployed because of failed fit tests, If this was to occur a record would be held centrally with BI and also with the local manager and staff health and wellbeing.	Not identified any staff to date	Process to be agreed and put in place	New Measures	
• following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• To date no staff have needed to be redeployed because of failed fit tests, If this was to occur a record would be held centrally with BI and also with the local manager and staff health and wellbeing	Not identified any staff to date	Process to be agreed and put in place	New Measures	
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system	• Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine ○ 289/400 fitted on reusable masks. Completion date anticipated 4.12.20. ○ IT designed database for recording of results live	Given the move to automated fit testing and reassessments, the process needs to be embedded to enhance opportunities for procurement to provide the equipment already tested for, specific to the areas.	Enhance fit testing overview centrally and locally to allow procurement to be targeted to areas where equipment already tested for. Sit rep to be developed reporting level of testing completed in conjunction of FFP3 respirators	New Measures	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
should include a centrally held record of results which is regularly reviewed by the board	• 20.11.20 – 2,776 results now live (includes all test results).		available. This will be reported through Silver and Gold command structures then to Board		
• 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 emergency care pathways, as per national guidance	• 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		
• all staff adhere to national guidance on social distancing (2 metres) 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)	None Identified	N/A		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• We have identified Covid secure areas and are also staggering staff break / rest times. • Area risk assessments have been undertaken and relevant information regarding status and capacity is displayed to maintain social distancing.	None Identified	N/A	New Measures	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (July 20)	New BRAG Rating (Nov 20)
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Staff have to wear facemasks at all times in all areas. Communications have been circulated via Trust News and ward walkers. Signage is posted at the entrance to Covid secure areas.			New Measures	
• 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 and testing is available for staff who are isolating. • Staff who are self-isolating have been supported by managers as part of normal absence arrangements.	None Identified	N/A		
• staff that test positive have adequate information and support to aid their recovery and return to work.	• All staff 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. • Asymptomatic swabbing results, staff are informed by text if negative and Health and Wellbeing Team if positive.	None Identified	N/A		

Southport and Ormskirk Hospital NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB194/20**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Management Team (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance & Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

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

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

Recommendation

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

Previously Considered By:

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

Strategic Objectives

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

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

Activity Summary – October 2020

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	October 2019	September 2020	October 2020	Trend
Overall Trust A&E attendances	10,601	8,774	7,904	↓
SDGH A&E Attendances	5,008	4,317	4,117	↓
ODGH A&E Attendances	2,538	1,650	1,341	↓
SDGH Full Admissions Actual	1,220	1,220	1,223	↑
Stranded Patients AVG	177	145	154	↓
Super Stranded Patients AVG	67	43	46	↓
MOFD Avg Patients Per Day	73	40	28	↓
DTOC Unconfirmed Avg Per Day	11	-	-	
GP Referrals (*Exc. 2WW*)	2,626	1,403	1,629	↓
2 Week Wait Referrals	826	784	701	↓
Elective Admissions	204	153	174	↓
Elective Patients Avg. Per Day	7	5	6	↓

Activity Summary – October 2020

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	October 2019	September 2020	October 2020	Trend
Elective Cancellations	24	20	24	
Day case Admissions	2,020	1,367	1,419	▼
Day Case Patients Avg. Per Day	65	46	46	▼
Day Case Cancellations	46	19	22	▼
Total Cancellations (EL & Day Case)	70	39	46	▼
Total Cancellations (On or after day of admission, non clinical reasons)	2	3	5	▼
Outpatients Seen	24,020	20,958	21,039	▼
Outpatients Avg. Per Day	775	699	679	▼
Outpatients Cancellations	4,195	4,131	3,585	▼
Theatre Cases	618	428	461	▼
General & Acute Beds Avg. Per Day	363	446	442	▲
Escalation Beds Avg. Per Day	6	0	2	▼
In Hospital Deaths	75	56	84	▲

Southport and Ormskirk Hospital NHS Trust

Trust Board - Integrated Performance Report

Head of Information Summary

Across the 86 indicators which make up the IPR for Trust Board the committee can be assured of 4, which is 2 more than last month. In the Quality section Sepsis – Timely Identification and the HSMR are assured. In Operations the A&E Conversion rate and in Workforce the Mandatory Training metric are assured. There are however a number of indicators which are intermittent in their assurance – that is they are neither consistently passing nor failing – but whose recent variation is statistically significant enough to flag them as having positive variation. Positive variation is an indication that the measure has shown significant improvement in performance over the past three months but does not indicate whether the measure has hit its target or plan in this time so may still require scrutiny from the Exec lead.

The 18 indicators which are failing to provide assurance include 2 from Quality, 5 in Operations, 2 in Finance and 8 in Workforce. In addition to these there are a number of indicators which are not assured, whose recent variation is not statistically significant or negative, and are not close to meeting their target or plan. These indicators require a) clarification and explanation b) a corrective action plan which aims to identify issues; defines actions with timeframes; and offers mitigations to improve in the immediate future.

In the Quality section the following indicators were highlighted to the Executive lead for additional comments this month – VTE, WHO Checklist, Safe Staffing, MSSA infection rate, Caesarean Rates, Induction rates, and the death screening rate.

For Operations indicators in Access, Cancer and Productivity were identified including Stroke, TIA, RTT (various), Cancer 14 Day, 31 Day treatment and 62 Day, ODGH bed occupancy, SDGH and ODGH theatre utilisation. The Operations section this month includes the new proforma indicator support templates which outline the additional detail being asked for to support the IPR.

In the Finance section the % Agency staff (cost) was highlighted to require additional narrative however given the extraordinary financial contracting arrangements at present an over-arching position should be provided.

Finally in the Workforce section Expenditure on bank/agency staff, PDR's, Nursing sickness rate, Non clinical staff sickness rate, Sickness rate non Covid-19 related, Medical vacancy rate and Nursing vacancy rate all require additional narrative as they are unassured and or are trending with negative variation. A new indicator has been included in this section showing the % of staff who would recommend the Trust as a place to work.

NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report

Board Report

October 2020

Southport and Ormskirk Hospital NHS Trust

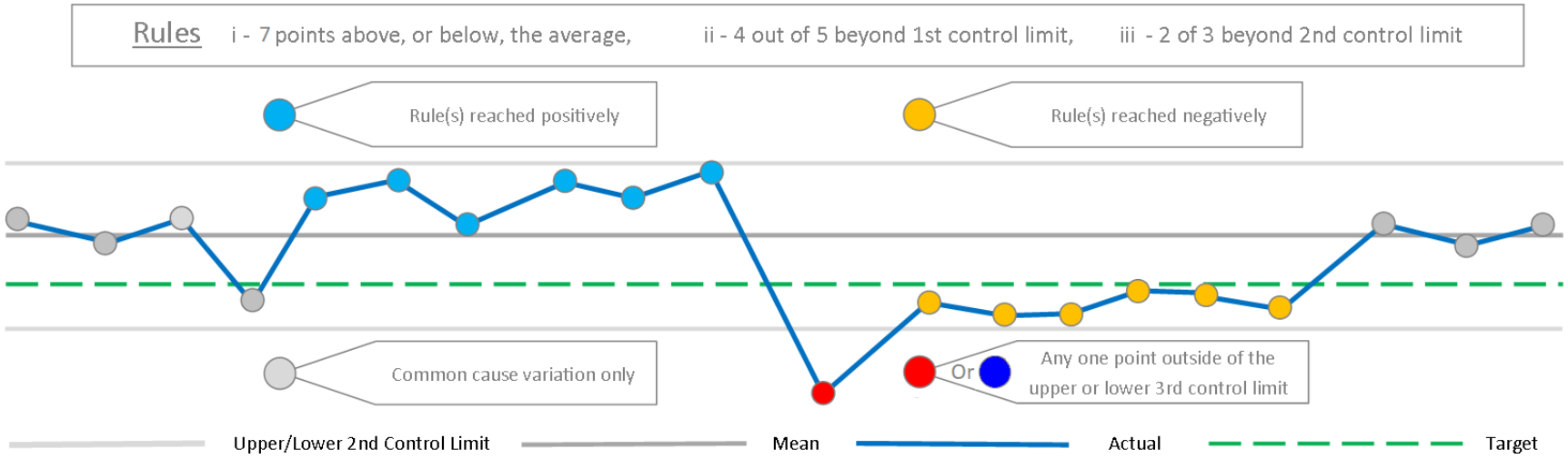
Guide to Statistical Process Control

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

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

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

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



NHS Southport and Ormskirk Hospital NHS Trust

Executive Summar

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Harm Free	0	1	12	0	2	2	1	8
	Infection Prevention and Control	0	0	4	1	0	0	0	3
	Maternity	0	0	9	1	0	0	1	7
	Mortality	1	1	1	0	0	0	1	2
	Patient Experience	1	0	5	0	0	1	2	3
Operations	Access	2	0	11	4	2	1	4	2
	Cancer	0	0	3	0	0	1	0	2
	Productivity	3	1	6	2	2	0	4	2
Finance	Finance	2	0	8	1	1	3	2	3
Workforce	Agency	1	0	0	1	0	0	0	0
	Organisational Development	1	1	1	0	1	0	0	2
	Sickness, Vacancy and Turnover	6	0	5	4	0	0	0	7

Assurance

Measures the likelihood of targets being met for this indicator.

?	Indicates that this indicator is inconsistently passing and falling short of the target.
P	Indicates that this indicator is consistently passing the target.
F	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.
L H	Indicates that there is positive variation recently for this indicator.
L H	Indicates that there is negative variation recently for this indicator.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY and SAFETY COMMITTEE (QSC)**
MEETING DATE:	**23 NOVEMBER 2020**
LEAD:	**DR DAVID BRICKNELL**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The mandated use of lateral flow tests for all patient facing staff may have a short-term impact on staffing levels as they are likely to reveal a level of asymptomatic illness.
- Although nosocomial infection has reduced, the most important factor is bed spacing and this will be addressed with new screens between beds to maintain capacity.
- Patient discharge will continue to be adversely affected by the availability of step down, non-acute care, particularly in West Lancashire, and the availability of nursing home accommodation for patients who are not clear of COVID.

ADVISE

- Investigation of Section 42 complaints regarding discharge show that the procedure is being inappropriately used in some cases to register concern. Better communication at the time of discharge should alleviate most of these concerns.
- Issues flagged at the last meeting, including TIA, SJRs in relation to COVID related deaths and diabetes prescribing, have all been clarified and acted on.
- The appointment of a dedicated discharge co-ordinator, in conjunction with the CCG, should help to resolve the complexity of multi-agency involvement at the point of discharge.

ASSURE

- The PALS system of contacting patients/families with concerns has significantly reduced the number of complaints.
- CQC discussions have indicated significant support of the actions we have taken, and the report demonstrated the Trust's wide-ranging initiatives, particularly in the well lead domain.
- The appointment of a Specialist Tissue Viability Nurse is having a positive impact on the awareness and reduction of hospital acquired pressure ulcers.

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

Review of the Risk Register

Southport and Ormskirk Hospital NHS Trust

Quality

Harm Free

Analyst narrative:

VTE Prophylaxis Assessment continues to show negative variation although it has achieved plan in October for the first time since March. This indicator requires further narrative to provide assurance that this will be sustained.
Compliance with the WHO Checklist is showing negative variation; although 100% compliance has been achieved in October. An issue with completion of the necessary field on the Theatre system (Galaxy) has come to light which affected the data quality in September.
Safe staffing, whilst showing no significant variation, continues to perform below plan and requires further operational narrative.

Operational narrative:

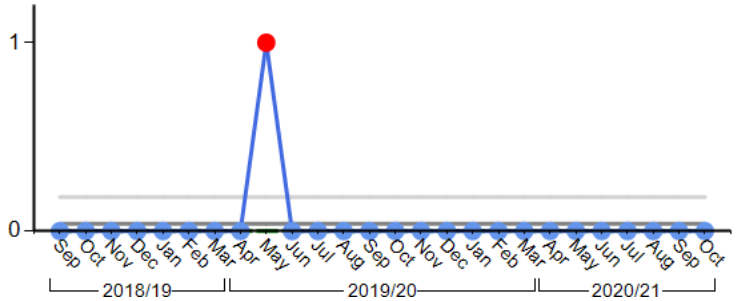
VTE
Improvements have been seen but work continues in urgent care to ensure the data accurately captures the right people who need assessment following the reorganisation in the emergency department and the conversion of some areas to assessment areas for COVID-19 escalation. All other areas are performing in line with target.

WHO checklist
The reduction in performance evident in September relates to an inputting error by a temporary member of staff and has been rectified.

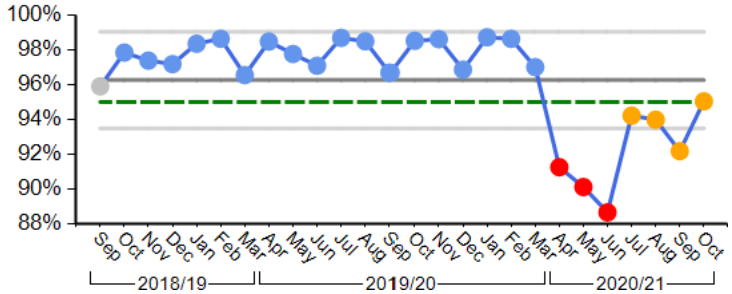
Safe staffing
The 90% safe staffing has not been achieved in month. Given the continued high bed occupancy in some areas and response to Covid-19 activity we continue to trigger escalation plans to support safe staffing requirements inclusive of staff re-deployment.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Oct 20	L	0	0	Sep 20	0	0	?
VTE Prophylaxis Assessments	95%	95%	170	Oct 20	L	95%	92.2%	Sep 20	95%	92.4%	?
Falls - Moderate/Severe/Death	0	0	0	Oct 20		0	1	Sep 20	0	5	?
Patient Safety Incidents - Low, Near Miss or No Harm	822	772	772	Oct 20		822	708	Sep 20	822	4512	?
Safe Staffing	95%	90.4%	N/A	Oct 20		95%	88.6%	Sep 20	95%	89.3%	?
Fractured Neck of Femur - Operated on within 36Hours	90%	66.7%	18	Oct 20		90%	90%	Sep 20	90%	69.8%	?
Hospital Pressure Ulcers - Grade 2	1	7	N/A	Oct 20		2	2	Sep 20	18	40	?
Hospital Pressure Ulcers - Grades 3 & 4	1	2	2	Oct 20		1	0	Sep 20	1	6	?
WHO Checklist	99.9%	100%	0	Oct 20	L	99.9%	98.6%	Sep 20	99.9%	99.7%	?
Sepsis - Timely Identification	75%	100%	N/A	Aug 20	H	75%	100%	Jul 20	75%	100%	P
Sepsis - Timely Treatment	75%	69.6%	N/A	Aug 20		75%	75%	Jul 20	75%	74.7%	?
Care Hours Per Patient Day (CHPPD)	7.9	9.1	N/A	Oct 20	H	7.9	9.2	Sep 20	7.9	10.4	?

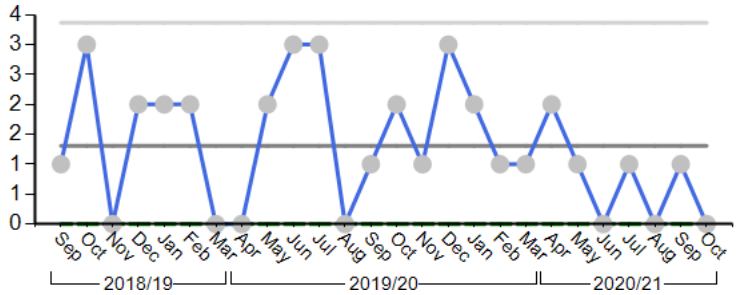
Never Events



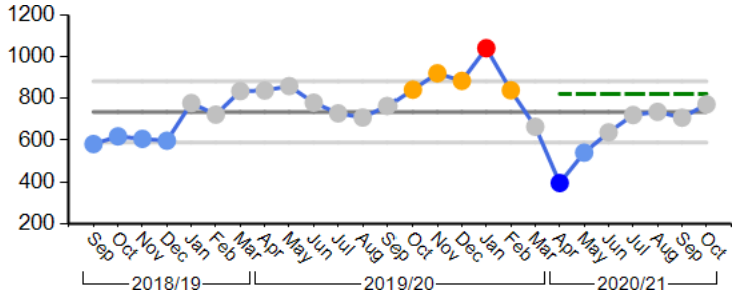
VTE Prophylaxis Assessments



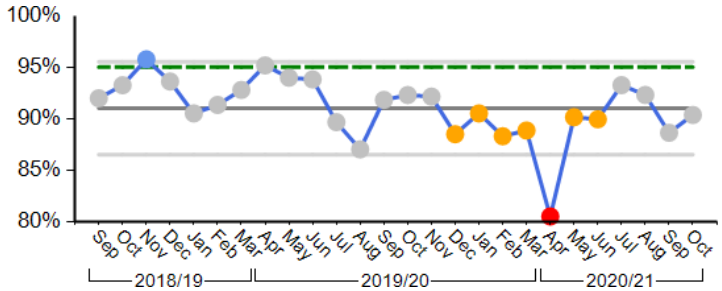
Falls - Moderate/Severe/Death



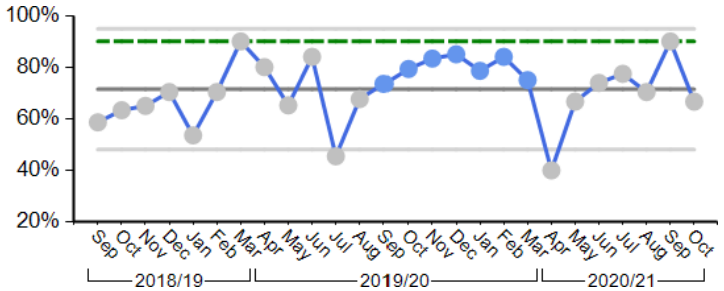
Patient Safety Incidents - Low, Near Miss or No Harm



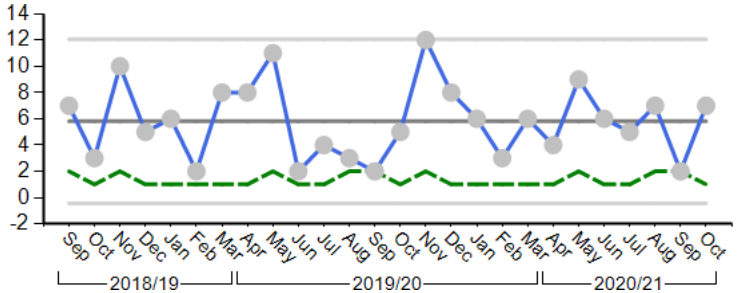
Safe Staffing



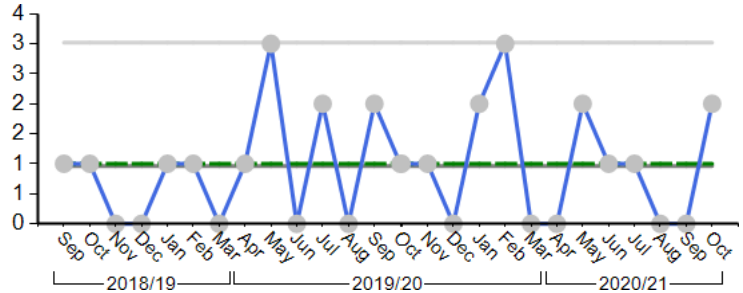
Fractured Neck of Femur - Operated on within 36Hours



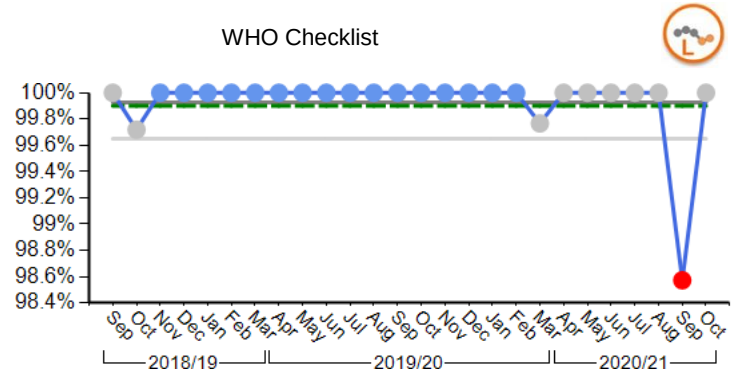
Hospital Pressure Ulcers - Grade 2



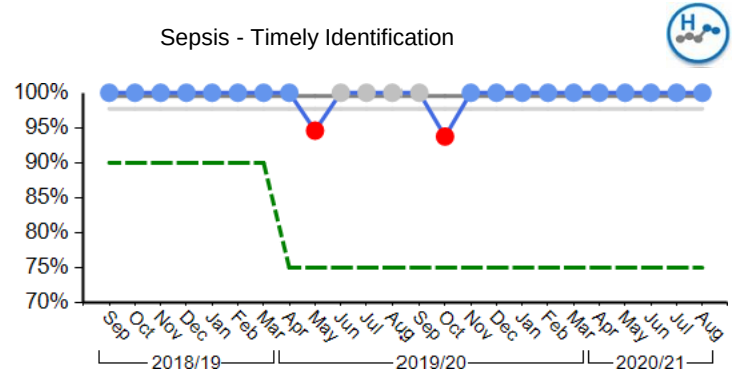
Hospital Pressure Ulcers - Grades 3 & 4



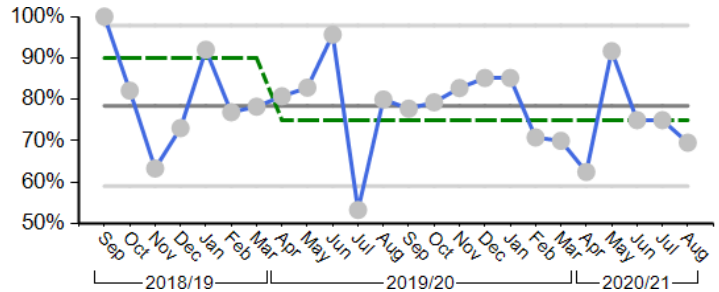
WHO Checklist



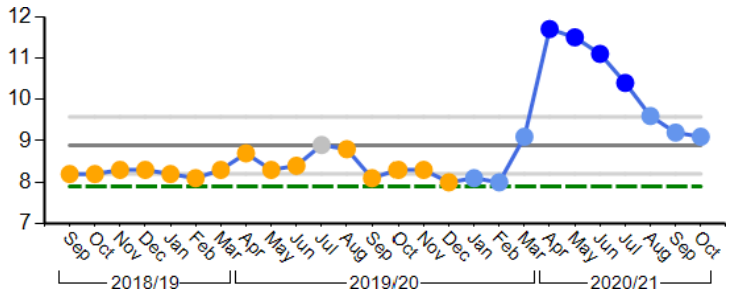
Sepsis - Timely Identification



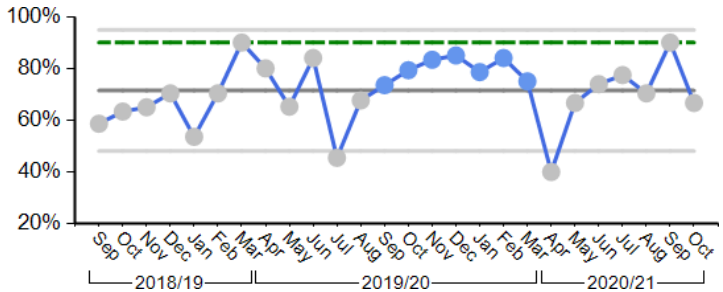
Sepsis - Timely Treatment



Care Hours Per Patient Day (CHPPD)



Fractured Neck of Femur - Operated on within 36Hours



Quality

Infection Prevention and Control

Analyst narrative:

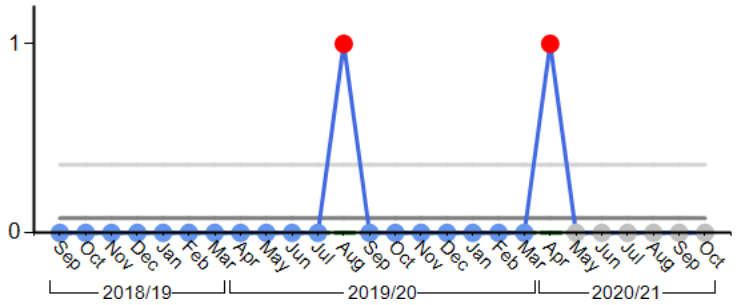
All 4 indicators are showing inconsistent assurance and, with the exception of MSSA, showing no significant variation. Whilst MSSA is showing recent negative variation, there were 0 cases in October resulting in a reduction in rate in line with the mean.

Operational narrative:

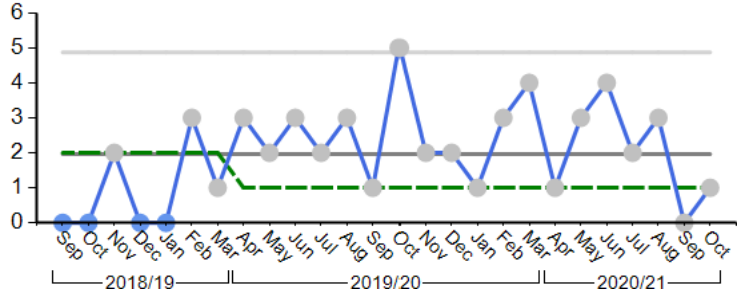
The increased IPC measures with respect to Covid-19 coupled with the changes made to the antimicrobial policy have produced improved results this month with respect to the 4 indicators. With respect to MSSA over the last three months the Trust has reported just 2 cases, the sources of infection being a hospital acquired pneumonia and a central line infection. The Trust is continuing to promote appropriate antimicrobial prescribing using the ARK (Antibiotic Review Kit), oral hygiene and ANTT (aseptic non-touch technique) – these measures are in place to prevent these type of infections from occurring.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Oct 20		0	0	Sep 20	0	1	
C-Diff	1	1	1	Oct 20		1	0	Sep 20	15	14	
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	8	N/A	Oct 20		6.9	8.7	Sep 20			
E. Coli	2	1	1	Oct 20		2	2	Sep 20	2	11	

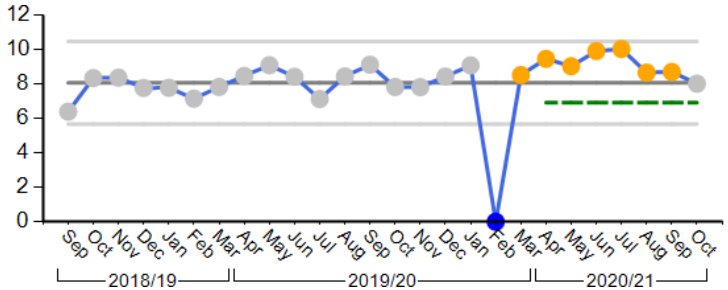
MRSA



C-Diff



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



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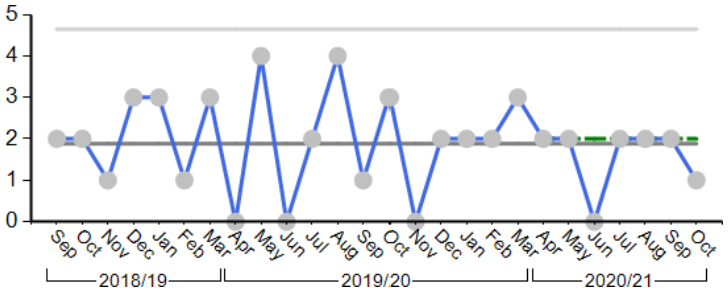


Quality

Maternity

Analyst narrative:

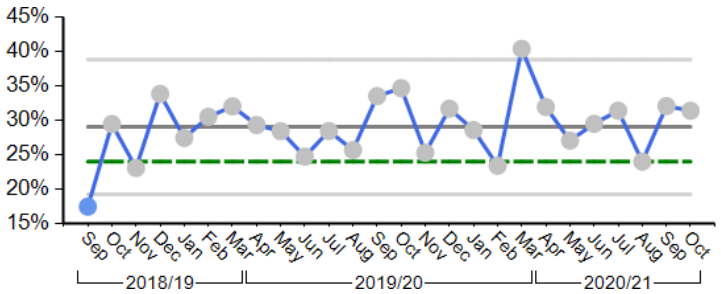
Whilst no maternity indicators are assured none are currently failing to provide assurance.
The number of Stillbirths is showing negative variation since June 2020, this indicator requires further narrative to provide assurance. Induction rates and 3rd/4th degree tears, whilst performing within control limits, are failing to get close to the target, suggesting either the need for a revision to the plans or detailed action plans to address the issues.

Operational narrative:

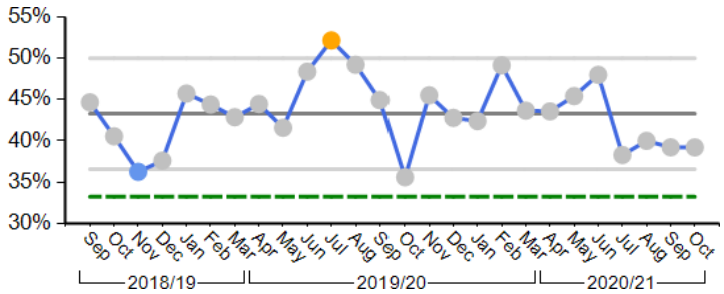
For the period June – October 2020 (inclusive) there has been 5 stillbirths.
All stillbirths and deaths are reviewed at the weekly patient safety meetings and reported to SIRG via a 72 hour review report. Following which a full investigation is carried out by a multidisciplinary panel including external representation. The parents are also invited to attend if they wish to or can contribute to the investigation by asking questions about their care. The reviews of these stillbirths identified no themes.
There is a plan to undertake a three year retrospective review of stillbirths that have occurred to identify themes and ensure embedding of any lessons.
There has been a noted increase in term babies admitted to the neonatal unit. These are also reviewed. There has been some themes noted and these concerns have been raised by the CBU at SIRG. A plan is in place to have focused leadership on the Delivery Suite along with an improvement plan overseen by the Head of Midwifery and Clinical Director and to report back to SIRG in December 2020.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Caesarean Rates	24%	31.4%	64	Oct 20		24%	32%	Sep 20	24%	29.6%	
Induction Rate	33.3%	39.2%	80	Oct 20		33.3%	39.2%	Sep 20	33.3%	41.9%	
Breastfeeding Initiation	60%	61.5%	77	Oct 20		60%	60%	Sep 20	60%	60.4%	
Percentage of Women Booked by 12 weeks 6 days	90%	94.5%	10	Oct 20		90%	93.6%	Sep 20	90%	94%	
Number of Occasions 1:1 Care Not Provided	0	0	0	Oct 20	L	0	0	Sep 20	0	0	
Number of 3rd/4th Degree Tears	0	8	8	Oct 20		0	0	Sep 20	0	17	
Number of Maternal Deaths	0	0	0	Oct 20		0	0	Sep 20	0	0	
Number of Stillbirths		1	1	Oct 20	H		1	Sep 20		5	
Number of Maternity Complaints	0	1	1	Oct 20		0	0	Sep 20	0	3	

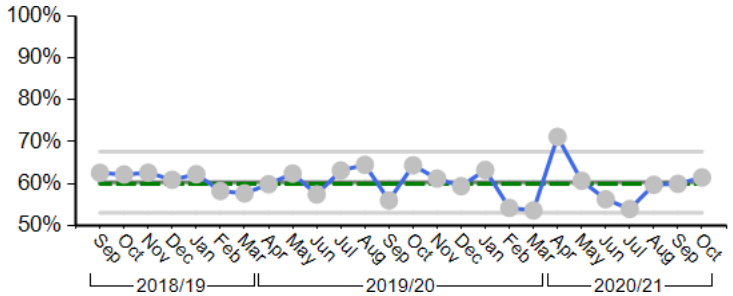
Caesarean Rates



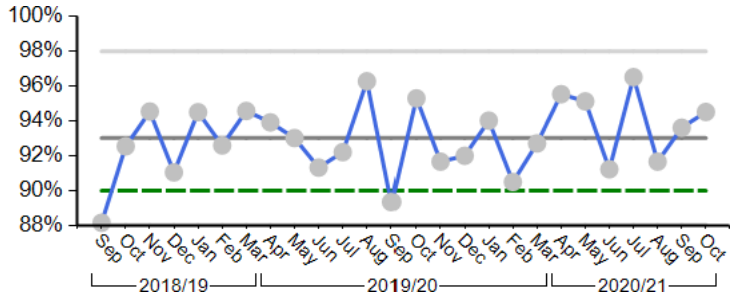
Induction Rate



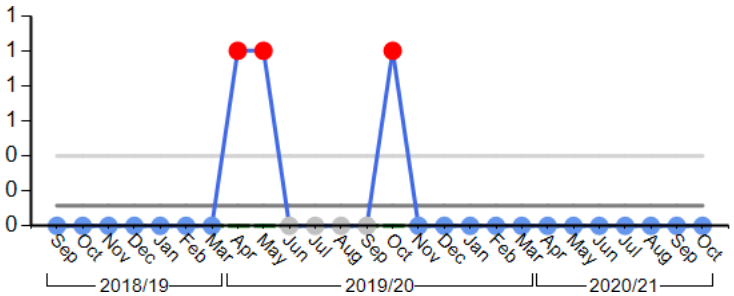
Breastfeeding Initiation



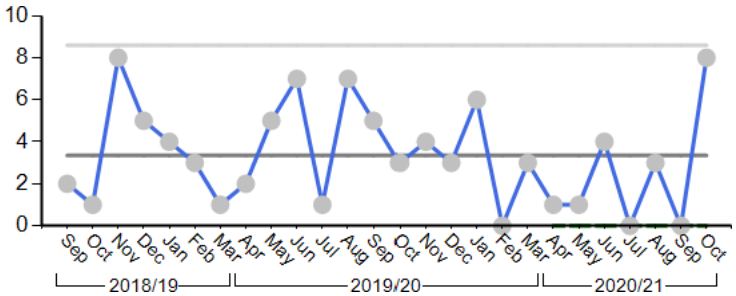
Percentage of Women Booked by 12 weeks 6 days



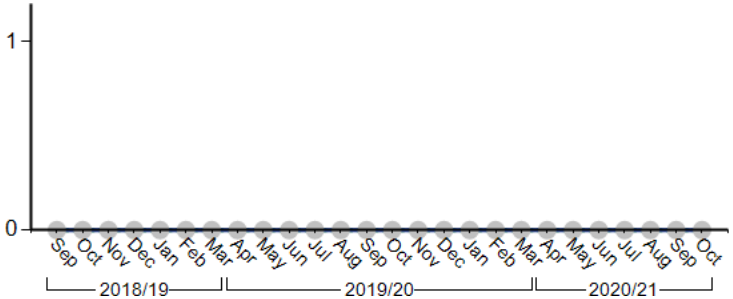
Number of Occasions 1:1 Care Not Provided



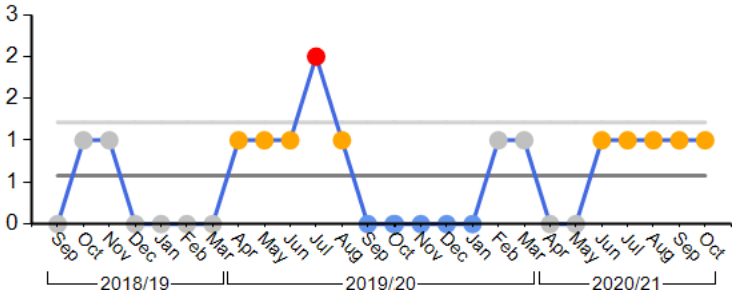
Number of 3rd/4th Degree Tears



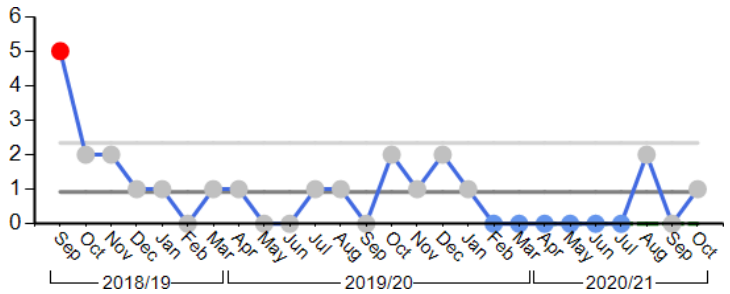
Number of Maternal Deaths



Number of Stillbirths



Number of Maternity Complaints



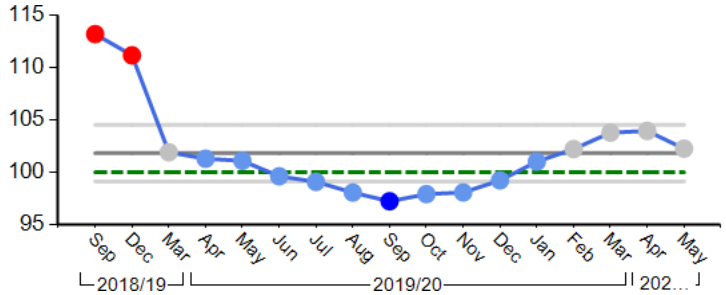
Quality

Mortality

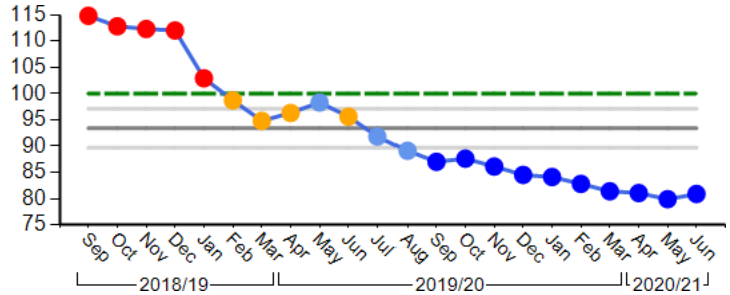
The SHMI is inconsistent in both assurance and variation, a slight decrease in month sees the Trust performance stay above plan for the 5th month. The HSMR, which looks at in hospital mortality as opposed to the SHMi which includes deaths post discharge, shows assurance and continues to trend down which is showing positive variation as well.
The screening rate has deteriorated again and still shows negative assurance.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	102.3	N/A	May 20		100	103.9	Apr 20	100	103.1	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	80.9	N/A	Jun 20	L	100	79.9	May 20	100	80.9	P
Percentage of Deaths Screened	100%	17.9%	46	Sep 20		100%	51.7%	Aug 20	100%	30.4%	F

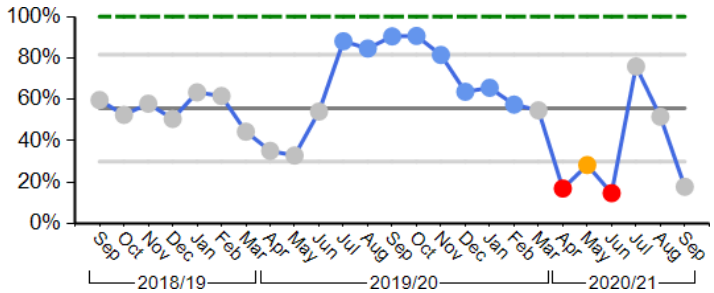
SHMI (Summary Hospital-level Mortality Indicator)



HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Quality

Patient Experience

Analyst narrative:

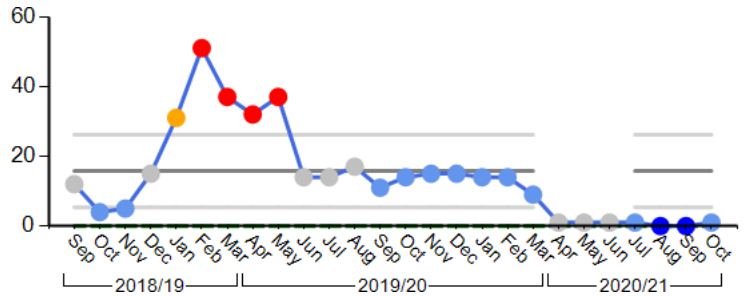
Delivering Same Sex Accommodation is failing to provide assurance with a breach reported in October. Numbers however remain very small with 2 reported in the current financial year. The complaints average turnaround time continues to show positive variation by performing ahead of plan. This was impacted by fewer complaints received during the first phase of Covid-19. This needs to be sustained with an increasing number of complaints in the last 2 months.
The Staff Friends and Family indicator has been amended this month to reflect the Staff Friends and Family Test - % who would recommend as a place for care or treatment. The plan is based upon the average figure for the Cheshire and Merseyside region. The Staff Friends and Family Test is currently suspended due to Covid-19.

Operational narrative:

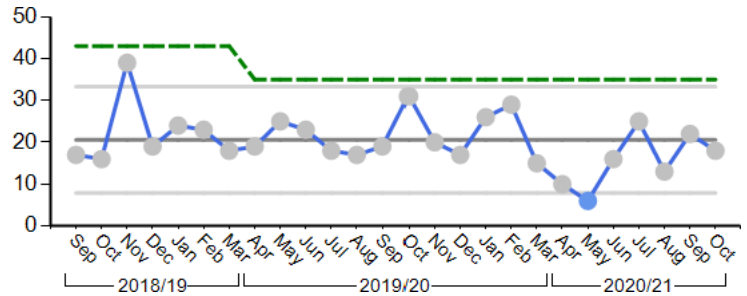
The mixed sex breach occurred due to a delay in transferring a patient out of Critical Care into a Ward bed due to bed capacity. The ITU Coordinator is escalating this at the Bed Meetings and it is fully documented on the Bed Report. Failure to meet this target could impact on bed capacity within Critical Care.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	1	1	Oct 20	L	0	0	Sep 20	0	2	F
Written Complaints	35	18	18	Oct 20		35	22	Sep 20	537	110	?
Complaints Average Turnaround Time	40	33.4	N/A	Oct 20	L	40	36.6	Sep 20	40	38	?
Duty of Candour - Evidence of Discussion	100%	100%	0	Oct 20	H	100%	100%	Sep 20	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Oct 20		100%	100%	Sep 20	100%	96%	?
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall	83%	77.6%	N/A	Mar 20		83%	65.3%	Sep 19	83%	66%	?

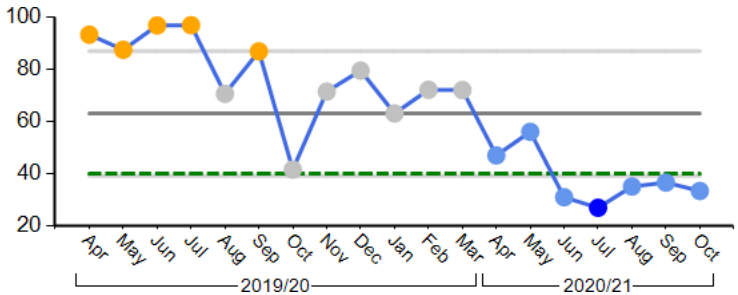
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



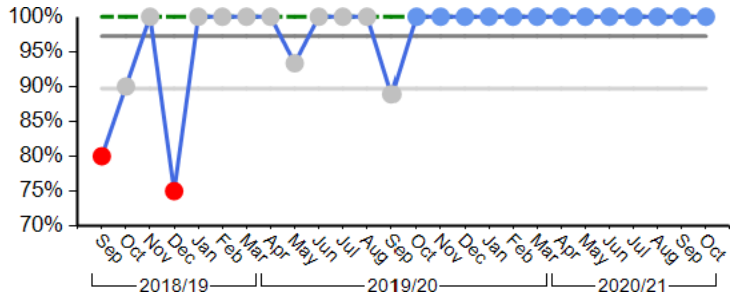
Written Complaints



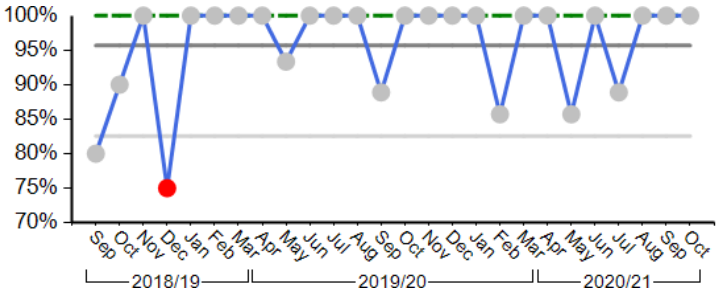
Complaints Average Turnaround Time



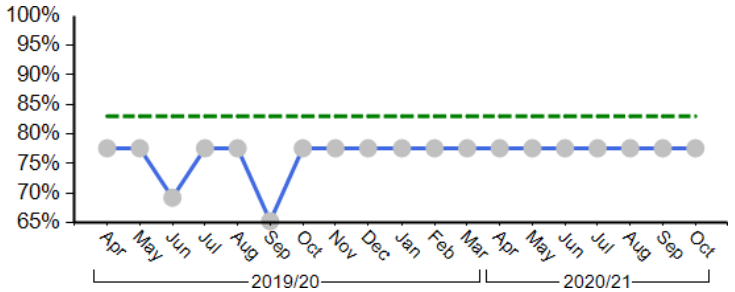
Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall



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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB195/20c**	**FOI Exempt**	**NO**
Report Title	**PATIENT EXPERIENCE STRATEGY** **PATIENT EXPERIENCE QUALITY IMPROVEMENT PLAN**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Claire Harrington (DDON)/ Michelle Kitson (Matron – Patient Experience)		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To present the Trust Patient Experience Strategy and Patient Experience Quality Improvement Plan

Executive Summary

Patient Experience Strategy.

The new patient experience strategy has been developed drawing themes from multiple sources of patient feedback and incidents. Four key areas have been identified:

1. Listening to our patients, carers and families and responding to their feedback.
2. We will provide a safe environment for our patients.
3. We will meet the physical and comfort needs of our patients.
4. We will provide a safe discharge for our patients

Consultation has been completed with Trust staff, external organisations and patient/carer representatives.

The decision was taken by the Trust Patient Experience and Community Engagement (PECE) group to implement the strategy over a four year period to compliment the Trust Equality and Diversity Strategy.

Please note that due to the locality of the Trust and the population that is served a separate Carers Strategy is also to be co-designed.

Patient Experience Quality Improvement Plan.

Following a peer review, the Quality improvement plan has been developed in partnership with the Head of Patient Faculty, Codesign and Practice at the NHS Leadership Academy. The aim of this QI plan is to begin to embed and increase the profile of patient experience across the organisation.

The Trust has secured a 2 days/week secondment from the Leadership Academy to lead on the implementation of this QI plan until January 2021.

Recommendation

For Trust Board to consider and approve the Trust Patient Experience Strategy and Patient Experience Quality Improvement Plan

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:**
Michelle Kitson – Patient Experience Matron Karl Roberts – Interim Associate Director of Patient Experience	Bridget Lees – Executive Director of Nursing

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NHS Trust

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

PATIENT EXPERIENCE STRATEGY

2020-2024

"It's the little things…there is nothing bigger"

Introduction

Please find supporting glossary of terms at the end of the strategy.

At Southport and Ormskirk Hospitals NHS Trust we want to ensure that all patients, carers and families from our local communities are engaged with, involved in their care and have a positive experience when they utilise our services. We want to ensure that their care is delivered by compassionate staff who are equipped with the skills to provide knowledgeable, compassionate, caring and safe care.

This strategy aims to create a culture where staff deliver care that is evidence based, but truly patient, carer and family focused. We have listened to staff, patients, carers and their families to understand what is required to improve and enhance care delivery. This direction has been taken from the Friend and Family Test Results, Local and National Survey results, Patient Stories, The National Audit of Dementia, Compliments, Concerns and Complaints data and results of Local Healthwatch Listening and Engagement Events. This has been considered alongside the National Patient Agenda where positive patient experience is fundamental for a quality healthcare provision.

The Strategy embraces the Scope for Change values of the organisation**: supportive, caring, open, professional and efficient** and supports the Trust strategic objectives which underpin the Vision 2020 and our mission to provide '**safe, high quality services for you with you'**

At Southport and Ormskirk Hospital NHS Trust we acknowledge the privileged position that we have in supporting both patients and carers through what can be one of the most vulnerable times in their lives.

We recognise the importance of every contact that we make with patients and their carer's and the impact we have on how they feel throughout their experiences when receiving care.

This strategy aims to heighten the profile of the patient experience within Southport and Ormskirk Hospital NHS Trust and promotes that a positive patient experience is the responsibility of all staff within the organisation.

As an organisation we provide healthcare to a diverse population across two hospitals and some community services i.e. Regional Spinal Injuries Unit, Maternity, Paediatric and Sexual Health services. The Patient Experience Strategy aims to continue to engage with the local community and the wider healthcare system to consider the needs of all.

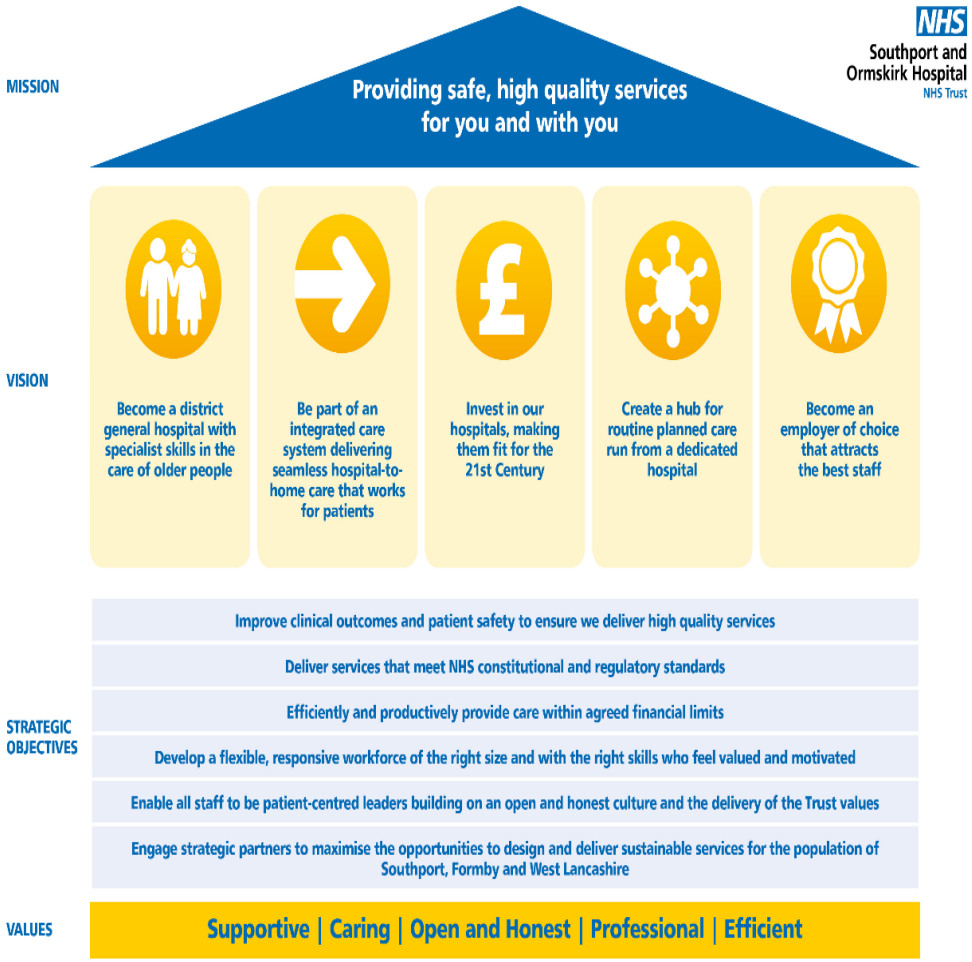
The strategy aligns with the Trusts Vision 2020 and other supporting Trust strategies and is designed to continue to meet the overarching values of the organisation.

The Trust's strategic mission reflects the importance of providing sustainable services for and with our patients and the local population. This is reflected in our mission statement:

"providing safe, high quality services for you and with you".

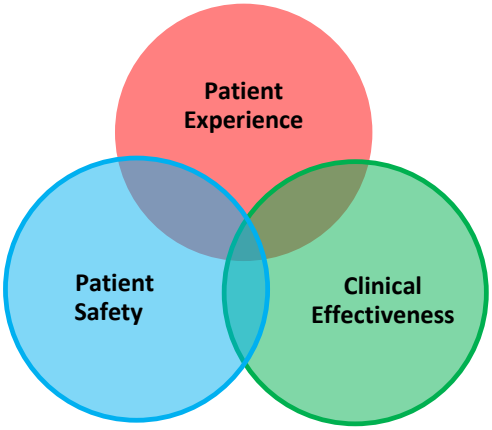
The next couple of years will be crucial to developing and making the organisation the best model for smaller NHS hospitals in the 21st Century it can be.

That is the ambition and aspiration behind Vision 2020 which was launched in the autumn of 2018. It is the Trust's road map - a strategy to how we will become a successful and sustainable provider of healthcare for local people.



Why Is Patient Experience Measurement Important?

It is integral that patient experience is seen as one of three important elements interlinking with clinical effectiveness and patient safety to ensure safe effective care is delivered to our patients. There is a strong evidence of the importance of this link identified between patient experience, clinical safety and effectiveness. For example, involvement in decision making and effective communication are strongly associated with improved patient safety and better self-reported clinical outcomes. The Francis Report (Robert Francis QC, 2013) called for a whole service patient centred focus. A series of avoidable death inquiries including the Mid-Staffordshire, Morecambe Bay and Gosport have recommended listening to patient feedback as a vital safety measure.



Underpinning this strategy is a continuous national drive to enable NHS services to become better at listening, understanding and responding to the needs and wishes of patients and the public. The importance of this is recognised by NHS England who state:

"The experience patients have of the treatment and care they receive – how positive an experience people have on their journey through the NHS can be even more important to the individual than how clinically effective care has been."

NHS England

The Trust has taken into account national policy that has informed our approach, this is listed below along with a brief description of the key underpinning messages:

• **The Operating Framework for the NHS in England 2012-13 (Dept. of Health 2011)** sets out the case for commissioners and providers to work together to improve the experience of patients, carers and the public.

• **NHS Outcomes Framework 2019 Domain 4b** ensuring people have a positive experience of care.

- **CQC Key Lines of Enquiry – Well Led (W7)** asks the question 'Are the people who use services, the public, staff an external partners engaged and involved to support high-quality sustainable services?'

• **The Health and Social Care Act (2014)** which includes the requirement to look at people's needs and experiences of care.

• **The Equality Act 2010** sets out to eliminate discrimination and inequalities.

• **The Accessible Information Standard (2016)** directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

Monitoring & Evaluation

Information that has informed this strategy has been taken from Friends and Family Feedback, patient stories, concerns/complaints, incidents, results of National Patient Experience Surveys, Patient Led Assessment of the Clinical Environment and the National Audit of Dementia. Collation of this data has generated four key areas of improvement underpinning the 2020-2024 strategy.

Each area of the strategy is relevant to every member of staff at Southport and Ormskirk Hospital NHS Trust and will be led by the Trust Board and facilitated by the Deputy Director of Nursing and Matron for Patient Experience.

Whilst the Deputy Director of Nursing and the Matron for Patient Experience are responsible for providing expert support, guidance and staff development to assist the delivery of this strategy, the Trust Board, the Chief Executive, Executive Directors, and Non-Executive Directors have a key role in:

- Supporting an organisational culture that values and embraces patient experience and involvement.
- Supporting and guiding the ongoing development of the strategy.
- Assuring itself that the views and feedback received from patients, carers and family is used to enhance and further develop the services that the Trust offers.

The strategy will be implemented and measured on an incremental basis over the next four years. The Trust Patient Experience and Community Engagement (PECE) Group will provide formal monitoring and evaluation throughout this time and report upwards to the Trust Quality and Safety Committee and Trust Board.

The success of the strategy will also be monitored through patient consultations supported by our local Healthwatch who work in partnership with the organisation to support improvements to the patient experience and services we deliver. Progress will also be monitored externally by our local Clinical Commissioning Groups.

The Trust Board

EXECUTIVE DIRECTORS

NHS Southport and Ormskirk Hospital NHS Trust

Trish Armstrong-Child
Chief Executive

Therese Patten
Acting Chief Executive

Steve Christian
Chief Operating Officer

Bridget Lees
Executive Director of Nursing Midwifery and Therapies

Dr Terry Hankin
Medical Director

Jane Royds
Director of HR and OD

Steve Shanahan
Director of Finance

NON-EXECUTIVE DIRECTORS

NHS Southport and Ormskirk Hospital NHS Trust

Neil Masom
Chair

Jim Birrell
Non-executive Director

David Bricknell
Non-executive Director

Graham Pollard
Non-executive Director

Pauline Gibson
Non-executive Director (designate)

Julie Gorry
Non-executive Director

Gurpreet Singh
Non-executive Director

Consultation and Acknowledgement

Acknowledgement and thanks is given to those groups and individuals that participated in the consultation process of this strategy:

- Members of the Trust Patient Experience And Community Engagement Group (including patient representatives).
- Matrons and Ward Leaders.
- Members of the Trust Dementia Strategy Group (including carer representatives)
- Members of the Trust Learning Disability Group. (including carer representatives)
- Members of the Trust Sensory Group.
- Trust Board of Non -Executive Directors.
- Trust Staff via the 'Meeting Place' closed Facebook Group and Trust News.
- Colleagues at the NHS Leadership Academy.
- Local Healthwatch and Healthwatch Community Champions.
- Local Clinical Commissioning Groups.

Review of the previous strategy

The patient experience strategy 2017-2019 'Developing The Experience of Care' described 8 pledges to support improvements to both the patient and carer experience. Key achievements from this strategy are as below:

- Johns Campaign - a number of 'Z' beds have been purchased to ensure a comfortable night for unpaid carers that are supporting patients with enhanced care needs.
- The hospital passport has been reviewed and re-launched.
- An increased number of noticeboards have been provided for third sector organisations to populate with information.
- #hellomynameis campaign relaunched in July 2019 to encourage all staff to introduce themselves to support delivery of compassionate care.
- Successful pilot of catering assistants has led to a number of substantive roles on acute wards.
- Initiation of Red2Green Board rounds to assist in the identification of 'wasted time' in a patient's journey.
- The opening of a new discharge lounge providing patients with an improved comfortable environment to await discharge.
- Development of a combating loneliness leaflet highlighting local services.
- Implementing a new FFT system using text messaging and automated calls to collect patient feedback has demonstrated a 15% increase in Trust response rates.
- The Garden of Reflection at Southport DGH was opened in September 2018 and the Baby Garden was re-opened on the Ormskirk DGH site in September 2020. Both areas provide a peaceful environment for staff, patients and families to reflect and remember those that have been lost.
- Review of nursing uniforms to reduce variation and support identification of roles.

John’s Campaign

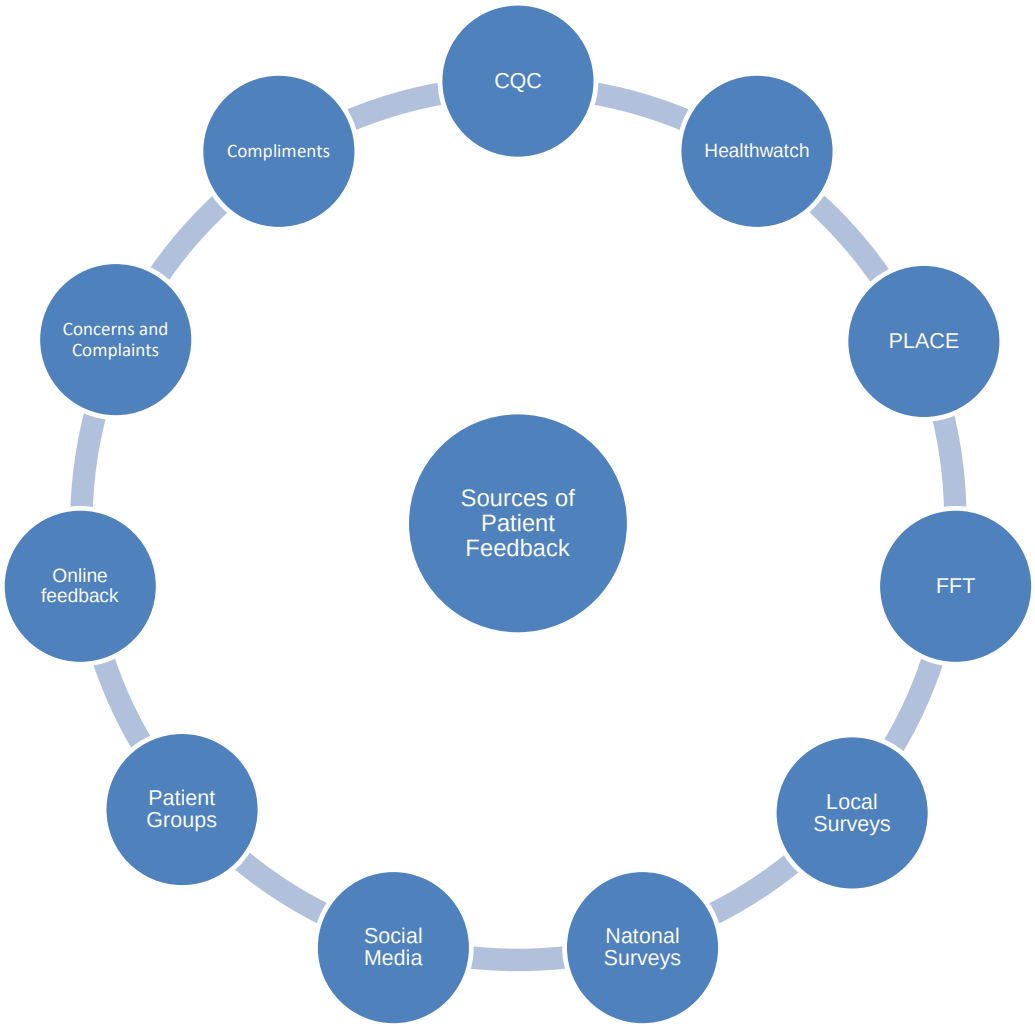
Discharge Planning Managing Loneliness

Official opening of our Garden of Reflection

Key Areas

1. Listening to our patients, carers and families and responding to their feedback.

The Trust is committed to improving our patient/carer engagement and listening to feedback from our patients, their carer's and families to understand their experiences. As seen below, feedback is collected in many forms, from patient survey results to complaints, concerns and compliments. This in turn allows us to understand what is important when delivering high quality patient care and enables us to use this knowledge in the design of our services. The change of focus within the new NHS England Friends and Family Test from April'20 will support opportunities for patients/carers to offer feedback throughout their journey of care. It will also encourage a 'You said….We did' approach to demonstrate how feedback is used across the organisation to make improvements to the patient/carer experience.



To do this we will:

- Gain real time feedback from our patients using methods that suit their needs.
- Use Friends & Family Test feedback to improve the patient experience.
- Continue to complete and respond to the results of the National Patient Experience Surveys for Adult Inpatients, Urgent and Emergency Care, Children and Young People Maternity and Cancer Survey results.
- Develop the skill of frontline staff to translate feedback into local actions.
- Engage with a diverse number of local community groups to develop communication opportunities to obtain patient/carer feedback.
- Continue to work in partnership with local Healthwatch groups.

To know we are making a difference we will:

- Utilise Friends and Family Test feedback by sharing it with all staff, from the front line to the Executive Board on a monthly basis.
- Use a 'You said…We did' approach to communicate to patients/carers and visitors what actions have been taken as a result of patient/carer feedback.
- Improve National Inpatient Survey performance with regards to questions on 'giving views on quality of care' and 'receiving information explaining how to complain'.
- Report on the themes of complaints alongside the number of complaints, concerns and compliments recorded by the organisation.
- Measure the volume and diversity of engagement with local community groups.
- Increase the number of patient engagement forums across the organisation.
- Respond to findings that are presented to us from local Healthwatch surveys.

2. We will provide a safe environment for our patients.

It is important to the Trust that, issues raised by our staff, patients or carers are dealt with in a timely manner. We also recognise that we have a diverse local community of which some have additional needs such as a learning disability, diagnosis of dementia, diverse first languages and sensory impairments. It is important to be able to be aware of these needs and record to develop our care planning to meet their requirements.

To do this we will:

- Continue to strengthen the 'freedom to speak up' initiative for staff to escalate concerns.
- Continue to monitor safe staffing levels on a regular basis.
- Ensure that patients can access services/information which meets their individual needs.
- Consult with service users during re-design of healthcare services and the physical environment.
- Reduce the response times to formal complaints

To know we are making a difference we will:

- Use safer staffing evidence based models to ensure that clinical areas are sufficiently staffed, therefore creating a safer care environment.
- Record and meet the requirements of patients individual communication/care needs.
- Implement software to increase the accessibility to information on our Trust website.
- Monitor performance in related standards of the Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS).
- Monitor and reduce the response times to formal complaints.
- Complete Equality Impact Assessments during re-design of healthcare services and the physical environment.

3. We will meet the physical and comfort needs of our patients.

A positive, comfortable environment, healthy food and access to hydration have a therapeutic effect on our patients and their recovery. We will ensure that both the physical and comfort needs of our patients are given priority at all times.

To do this we will:

- Continue to recruit volunteers across the organisation.
- Ensure patients have choice and access to safe nutritious food and hydration at all times.
- Develop the physical ward environment to improve the safety and comfort needs of the patient.
- Monitor patients on a regular basis and ensure their nutrition, oral care and comfort needs are attended to in a timely manner by competent staff.
- Identify patients/carers to offer referral to the spiritual care service as part of their admission process.
- Support the aims within the Trust Dementia strategy with regards to providing a stimulating environment conducive to patients maintaining physical, cognitive and social function.
- Create a positive and vibrant environment supporting patients with a diagnosis of dementia to feel safe and orientated.

To know we are making a difference we will:

- Continue to audit results related to nutrition i.e. Malnutrition Universal Screening Tool (MUST) scores, care planning and the measurement of patient weights.
- Launch ‘Mouth care Matters’ across all in-patient areas.
- Monitor Friends and Family Test feedback and themes of complaints in relation to basic care.
- Deliver on our actions in response to the outcomes of PLACE (Patient Led Assessment of the Clinical Environment).
- Monitor performance in related standards of the Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS).
- Increase the number of volunteers in befriending and dining companion roles.
- Continue to participate in the National Audit of Dementia and monitor results particularly in relation to nutrition and environment.
- Monitor the number of referrals made to the chaplaincy and spiritual care service.

4. We will provide a safe discharge for our patients

The Trust cares for one of the largest populations in the country who require support at home or are living in a setting providing 24 hr care. It is imperative that all patients and their carers participate in the discharge process and receive the right information to provide a safe discharge as to avoid further harm and a potential readmission to hospital.

To do this we will:

- Use the Always event methodology to design tests of change to ensure patients/carers know who to contact if they have a concern about their treatment or discharge.
- Work collaboratively with community care providers and system partners to improve our discharge processes.
- Involve patients, relatives and carers in the decisions supporting discharge plans.
- Increase the presence of pharmacy staff in the ward environment.

To know we are making a difference we will:

- Improve National Inpatient Survey performance with regards to questions on feeling involved in decisions about discharge from hospital, receiving information regarding what to /not to do when leaving hospital, information about medications and knowing who to contact with any concerns about treatment or clinical condition.
- Increase the number of pharmacy roles to enable increased support in the ward environment.
- Reduce the number of complaints/concerns received from patients and other external bodies regarding the discharge process.

Measuring our success

Successful implementation of the Patient Experience Strategy will aim to improve on the following outcomes:

- Consistently meet the Trust Friends and Family Test target of 94% of patients that will rate the overall experience of the service they receive from the Trust as Very good or Good.
- Reduction in the overall number of complaints received by the Trust.
- An increase in the number of complaints answered within a 40 day response time.
- Improved overall scores in the Patient-led Assessments of the Care Environment (PLACE).
- From April 2020 an increase in the number of wards achieving silver status in SONAAS assessments.
- Improved performance in the National Audit of Dementia. This will be demonstrated by an increase of 28% to a target of 80% in carers rating, and an increase of 19% at Southport Hospital and 26% at Ormskirk Hospital to increase dementia environment rating to 80% on both hospital sites.
- When benchmarked against other organisations, improved overall performance is recognised within the National Patient Experience Surveys for Adult Inpatients, Urgent and Emergency Care, Children and Young People Maternity and Cancer Survey results.

Summary

Aim	Actions	Measures	When
1. Listen to our patients, carers and families and respond to their feedback.	• Gain real time feedback from our patients using methods that suit their needs. • Use Friends & Family Test feedback to improve the patient experience. • Continue to complete and respond to the results of the National Patient Experience Surveys for Adult Inpatients, Urgent and Emergency Care, Children and Young People Maternity and Cancer Survey results. • Develop the skill of frontline staff to translate feedback into local actions. • Continue to work in partnership with local Healthwatch groups. • Engage with a diverse number of local community groups to develop communication opportunities to obtain patient/carer feedback.	• Utilise Friends and Family Test feedback by sharing it with all staff, from the front line to the Executive Board on a monthly basis. • Use a 'You said…We did' approach to communicate to patients/carers and visitors what actions have been taken as a result of patient/carer feedback. • Improve National Inpatient Survey performance with regards to questions on 'giving views on quality of care' and 'receiving information explaining how to complain'. • Report on the themes of complaints alongside the number of complaints, concerns and compliments recorded by the organisation. • Respond to findings that are presented to us from local Healthwatch surveys. • Measure the volume and diversity of engagement with local community groups. • Increase the number of patient engagement forums across the organisation.	**2022**
2. Provide a safe environment for our patients.	• Continue to strengthen the 'freedom to speak up' initiative for staff to escalate concerns. • Continue to monitor safe staffing levels on a regular basis. • Ensure that patients can access services/information which meets their individual needs. • Consult with service users during re-design of healthcare services and the physical environment. • Reduce the response times to formal complaints.	• Use safer staffing evidence based models to ensure that clinical areas are sufficiently staffed, therefore creating a safer care environment. • Record and meet the requirements of patients individual communication/care needs. • Implement software to increase the accessibility to information on our Trust website. • Monitor performance in related standards of the Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS). • Monitor and reduce the response times to formal complaints. • Complete Equality Impact Assessments during re-design of healthcare services and the physical environment.	**2022**

Aim	Actions	Measures	When
3. We will meet the physical and comfort needs of our patients	• Continue to recruit volunteers across the organisation. • Ensure patients have choice and access to safe nutritious food and hydration at all times. • Develop the physical ward environment to improve the safety and comfort needs of the patient. • Monitor patients on a regular basis and ensure their nutrition, oral care and comfort needs are attended to in a timely manner by competent staff. • Identification patients/carers to offer referral to the spiritual care service as part of their admission process. • Support the aims within the Trust Dementia strategy with regards to providing a stimulating environment conducive to patients maintaining physical, cognitive and social function. • Create a positive and vibrant environment supporting patients with a diagnosis of dementia to feel safe and orientated.	• Continue to audit results related to nutrition i.e. MUST scores, care planning and the measurement of patient weights. • Launch 'Mouth care Matters' across all in-patient areas. • Monitor Friends and Family Test feedback and themes of complaints in relation to basic care. • Deliver on our actions in response to the outcomes of PLACE (Patient Led Assessment of the Clinical Environment). • Monitor performance in related standards of the Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS). • Increase the number of volunteers in befriending and dining companion roles. • Continue to participate in the National Audit of Dementia and monitor results particularly in relation to nutrition and environment.	**2023**
4. We will provide a safe discharge for our patients	• Use the Always event methodology to design tests of change to ensure patients/carers know who to contact if they have a concern about their treatment or discharge. • Work collaboratively with community care providers to improve our discharge processes. • Involve patients, relatives and carers in the decisions supporting discharge plans. • Increase the presence of pharmacy staff in the ward environment.	• Improve National Inpatient Survey performance with regards to questions on feeling involved in decisions about discharge from hospital, receiving information regarding what to /not to do when leaving hospital, information about medications and knowing who to contact with any concerns about treatment or clinical condition. • Increase number of pharmacy roles to enable increased support in the ward environment. • Reduce the number of complaints/concerns received from patients and other external bodies regarding the discharge process.	**2023**

Southport and Ormskirk Hospital NHS Trust

GLOSSARY OF TERMS

Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONASS)

A framework designed around 15 standards subdivided into Environment, Care, and Leadership. The framework is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. Unannounced ward assessments are completed and wards are accredited with a level of 0-3. Wards are then reassessed at a time interval dependent on the results.

Patient Experience and Community Engagement Group (PECE)

The PECE meets bi-monthly and membership consists of Trust staff, Patient Representatives and external partners such as Healthwatch and Sefton Advocacy. The group receives National and local patient feedback reports and in response participates in projects to improve the patient, family and carer experience. The group also reviews new patient information in various formats.

Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS.

National Patient Experience Surveys

The NHS Patient Survey programme was established to support patients and the public to have a real say about the quality of NHS services and how they are developed. By asking organisations to carry out patient surveys in a consistent and systematic way, it is possible to build up a detailed picture across the country of patients' experiences. This approach not only allows organisations to compare their performance with others but, by repeating the same type of survey on a regular basis, progress and improvements over time can be monitored

Patient Led Assessment of the Clinical Environment (PLACE)

Patient Led Assessment of the Clinical Environment (PLACE) involves local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia.

Healthwatch

Healthwatch are the independent national champion for people who use health and social care services. They are here to find out what matters to people, and help make sure their

views shape the support they need. There is a local Healthwatch in every area of England. They support local Healthwatch to find out what people like about services, and what could be improved, and they share these views with those with the power to make change happen. Healthwatch also help people find the information they need about services in their area. They also encourage health and social care services to involve people in decisions that affect them.

Malnutrition Universal Screening Tool (MUST)

'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obesity. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

Links to National Survey Results

CQC National Patient Experience Surveys

https://www.cqc.org.uk/publications/surveys/surveys

NHS England Friends and Family Data

https://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

Patient Led Assessment of The Clinical Environment

https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place

https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/england---2019

National Audit of Dementia

https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia

Sefton Healthwatch

https://healthwatchsefton.co.uk/

Southport and Ormskirk Hospital NHS Trust

NOT STARTED
OVERDUE
IN PROGRESS
COMPLETE

Patient Experience and Engagement Delivery Plan: Southport and Ormskirk NHS Trust

Custodian of the plan: Michelle Kitson, Matron for Patient Experience **(Draft updated 07.07.2020)**

All Changes to this plan are to be updated and circulated by Matron for Patient Experience.

	IMPROVEMENT	ACTIONS	NOTES	SENIOR LEAD	OPERATIONAL LEAD (S)	START DATE	TARGET END DATE / IMPROVEMENT BY	FREQUENCY OF MONITORING	PERSONS' RESPONSIBLE / DELEGATED TO	METHOD OF MEASUREMENT (USUALLY VIA AUDIT)
Domain 1 - Strategy: Board and Senior Leadership Team	Compliments, Concerns Complaints and Incidents	Review compliments and complaints and triangulate and establish themes to further develop patient experience delivery plan.		DON	HON's	Sep-20	Oct-20	Quarterly		
	Appointment of Non - Executive Director Lead for Patient Experience	Director of Nursing to speak with CEO & Chairman.		DON	Deputy DON	Sep-20	Nov-20	Yearly		
	Board Assurance and Governance Structures	To be agreed with Senior Nursing Team and paper to board.		DON	Deputy DON	Sep-20	Oct-20	Yearly		
	Patient Experience Reports	To be agreed with Senior Nursing Team and paper to board.		DON	Matron for Patient Experience	Sep-20	Oct-20	Quarterly		
	Patient Stories @ Board Framework	Framework to be devised and agreed with a paper to board.		DON	Matron for Patient Experience	Sep-20	Oct-20	Yearly		
	Patient Experience & Engagement Strategy	To be coproduced and designed with patients and Trust staff.		DON	Matron for Patient Experience	Sep-20	Oct-20	Ongoing		
	CBU Patient Experience Strategy (Work plan)	Each CBU to design own patient experience work plan (strategy)								

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	Carers strategy	To be coproduced and designed with carers, staff and Sefton Carers Centre		DON	Matron for Patient Experience	Sep-20	Dec-20	Ongoing		
	Structure of Patient Experience and Engagement Team	To work with key stakeholders (Nursing, Finance and SLT		DON	Deputy DON	Sep-20	Nov-20	Ongoing		
	Accessible Information Standards	Benchmarking exercise to be completed and report to board on outcomes and work needed to meet standard.		DON	Assistant Director of Quality	Sep-20	Jan-21	Ongoing		
	Equality Impact Assessments	Raise the awareness of EIA across the Trust and the importance of impact of patients and carers is included as part of EIA. Training and development of staff in EIA and ensure that EIA is included in service change and Board reports.		Assistant Director of Risk and Governance	Equality and Diversity Lead	Sep-20	Jun-21	Ongoing		
	Peer Review	Establish connection and relationship with a Trust of similar size and undertake at least one peer review and shadowing opportunity per year for PE team.		DON	Deputy DON	Sep-20	Dec-20	Yearly		
	Patient Experience is part of JD's	Work with HR recruitment and trade unions to ensure that PE is part of all JD's and PS.		DofHR& OD	Head of HR	Sep-20	Jan-21	Ongoing		
	Recruitment and selection processes	Establish a framework to support patient and carer involvement on interview and selection panels for all paid and volunteering roles.		DofHR& OD	Head of HR	Sep-20	Jun-21	6 monthly		
Domain 2: Stakeholder, Patient, Carer, Staff, Community Leadership & Engagement										
	Patient Experience and Community Engagement Group	Redefine the role of PECE and review and refresh Terms of reference of the group		DON	Matron for PE	Sep-20	Jan-21	Yearly		
	Roles of patient partners	define and communicate the roles of Experience of Care Partners within the Trust		DON	Matron for PE	Sep-20	Jan-21	Yearly		
	Recruitment and Selection of Experience of Care Partners	Define roles of Trust Experience of Care Partners.		DON	Matron for PE	Sep-20	Jan-21	Yearly		

	Training of Experience of Care Partners	Establish core training and development offer for Experience of Care Partners.		DON	DDON	Oct-20	Jan-21	6 monthly		
	Workforce development	Establish framework for job opportunities from within pool of Experience of Care Partners.		DofHR	Head of Recruitment	Nov-20	Jan-21	6 monthly		
	Expenses Policy	Develop Trust expenses policy in line with NHSE/I		DoF	Head of Finance	Sep-20	Mar-21	Yearly		
	PLACE	Work with Key Stakeholders to train and develop PLACE Teams.		DON	Matron for Estates and Facilities/ Head of Facilities	Sep-20	Nov-20	Quarterly		
	Staff Patient Experience forum	Establish and Patient and Staff cochaired 'Staff and Patient Experience forum'		DoN	Matron PE	Sep-20	Sep-21	Quarterly		
	Emergency Department forum	Coproduce, co design an ED Forum		DoN	Matron A+E /HON	Sep-20	Sep-21	Quarterly		
	Children and Young Peoples forum	Coproduce, co design a Children's and Young peoples Forum		DoN	Matron Children's /HON	Sep-20	Sep-21	Quarterly		
	Sexual Health Services Forum	Coproduce, co design a Sexual Health Service User Forum		DoN	Matron Sexual Health/HON	Sep-20	Sep-21	Quarterly		
	Maternity Services forum	Coproduce, co design a maternity services Forum		DoN	Matron Maternity /HOM	Sep-20	Sep-21	Quarterly		
	Mortuary Services	Review of Mortuary services and environment		DoN	Matron PE/ Matron Estates and Facilities	Sep-20	Sep-21	Quarterly		
Domain 3: Communications (Internal and external)										
	Experience of Care Webpage	Refresh Experience of care webpage with staff and patients.		Do Strategy	Head of Comms	Sep-20	Dec-20	Yearly		
	Leadership development	Create link to NHS Leadership Academy Experience of Care webpage.		Do Strategy	Head of Comms	Sep-20	Dec-20	Yearly		
	Testimonials from partners	Seek testimonials from patients, carers, staff, commissioners and delivery partners and place on Trust webpage		Do Strategy	Head of Comms	Sep-20	Dec-20	Quarterly		

	Language services	Review and address unmet need and review existing language line and BSL/Deafblind Communication Services		Do Strategy	Procurement Manager/ Equality and Diveristy Lead	Jul-20	Nov-20	Quarterly		
	Patient Information Boards	Establish coproduction and codesign task and finish group to review patient boards.		DoN	Matron PE	Nov-20	Mar-21	Quarterly		
	Patient Communication Boards	Establish coproduction and codesign task and finish group		DoN	Matron PE	Nov-20	Mar-21	Quarterly		
Domain 4: Learning and Development	Staff and Volunteer induction	Explore the options to raise the profile of patient experience at staff /volunteer induction		DoN	Matron PE	Sep-20	Mar-21	Quarterly		
	Fundamentals in Patient Experience & QI for Trust staff	Deliver 4 Fundamentals in patient experience workshops during 2020/21		DoN	Matron PE	Sep-20	Sep-21	Quarterly		
	Inclusive Patient Engagement and Leadership	Deliver 4 Inclusive patient leadership workshops during 2020/21		DoN	Matron PE	Sep-20	Sep-21	Quarterly		
	Coproduction and codesign	Deliver 4 coproduction and codesign workshops during 2020/21		DoN	Matron PE	Sep-20	Sep-21	Quarterly		
	Interviewing Skills	Deliver 4 inclusive interviewing skills workshops during 2020/21		DoN	Head of HR	Sep-20	Sep-21	Quarterly		
	PLACE Assessment	Deliver 2 PLACE Team training sessions Q2 & Q4		DoN	Matron for Estates and Facilities/ Head of Facilities	Sep-20	Nov-20	Yearly		
	Edward Jenner Programme	Offer free online Leadership Academy Edward Jenner Programme to all.		DoN	Head of L&D	Sep-20	Nov-21	Quarterly		
Domain 5: Insights: Data, Evaluation and Feedback	Experience of Care Partner Database	Establish Experience of Care Partner database		DoN	Manager of Volunteers	Nov-20	Jan-21	Yearly		
	FFT Data collection	Review collection of FFT Data		DoN	Matron PE	Sep-20	Nov-20	Quarterly		

	FFT Data Analysis	Review and agree on themes and create QI plan and communicate to patients and staff and to include in reporting framework.		DoN	HON's	Oct-20	Dec-20	Quarterly		
	FFT Survey (Workforce)	Questionnaire and data analysis of qualitative data. Agree on reporting structure and themes.		DoN	Head of HR / Data Analyst	Oct-20	Dec-20	Quarterly		
	Inpatient Survey	Questionnaire and data analysis of qualitative data. Agree on reporting structure and themes.		DoN	Matron PE / Data Analyst	Sep-20	Sep-20	Quarterly		
	Cancer Survey	Questionnaire and analysis of qualitive data. Agree on reporting structure and themes.		DoN	Cancer Manager / Data Analyst	Sep-20	Oct-20	Quarterly		
	Maternity Survey	Questionnaire and data analysis of qualitative data. Agree on reporting structure and themes.		DoN	Maternity Matron / Data Analyst	Sep-20	Sep-20	Quarterly		
	You said we did	Review how the Trust communicates to patients, carers, families, Staff and external stakeholders.		DoN	Matron PE	Sep-20	Dec-20	Quarterly		
	Urgent and emergency Care (Adults)	Questionnaire and data Analysis of qualitative data. Agree on reporting structure and themes.		DoN	ED Matron / Data Analyst	Sep-20	Sep-20	Quarterly		
	Children and Young people	Questionnaire and data analysis of qualitative data. Agree on reporting structure and themes.		DoN	/Paediatric MatronData Analyst	Sep-20	Sep-20	Quarterly		
	Patient Leader programmes feedback and evaluation	Undertake analysis of qualitative feedback.		DoN	L&D Manager / Data Analyst	Jun-21	Aug-21	Quarterly		
	Sexual Health Services	Undertake analysis of qualitative data and agree on reporting structure and themes.		DoN	Sexual Health Matron / Data Analyst	Oct-20	Jan-21	Quarterly		
Domain 6: Celebrating success	PENNA Awards	Nominate Trust and Teams for National PENNA Award		DoN	Head of Comms	Jan-21	Ongoing	Yearly		
	HSJ Award	Nominate Individuals and Teams for HSJ Award		Doff Strategy	Head of Comms	Sep-20	Ongoing	Yearly		
	Nurses Day	Showcase Patient Experience Work on Nurses Day		DoN	Head of Comms	May-21	Ongoing	Yearly		

	Staff & Volunteer Awards	Review and establish new Categories for PE Awards and utilise Patient Leaders in presenting awards		Doff HR & OD	Head of Comms	Oct-20	Ongoing	Yearly		
	Thank you	Codesign a Staff and Volunteer 'Thank you' card		Doff HR & OD	Matron PE	Oct-20	Dec-20	Yearly		
	Wall of Achievements	Establish a wall of achievements		Dof Estates	Head of HR	Nov-20	Ongoing	Quarterly		

	Roles	Name	Job title
	Trust Accountable Officer		
	NED Lead	Julie Gorry	NED
	Executive Lead	Bridget Lees	DON
	Senior Operational and Strategic Lead	Claire Harrington	DDoN
	Clinical Operational Lead	Michelle Kitson	Matron for Patient Experience

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB196/20**	**FOI Exempt**	**NO**
Report Title	**QUALITY ACCOUNT**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The purpose of this report is to provide the Board with the latest version of the Trust's draft Quality Account for 2019 / 2020 for approval.

Executive Summary

- The Trust's mandated annual Quality Account is due for finalising in December 2020. Due to the COVID pandemic there has been a national extension.
- The draft document has been presented previously at Audit Committee and Quality & Safety Committee for comments.
- A presentation and a copy of the draft report has also been shared with CCGs, HealthWatch and Local Authority colleagues on 9 October 2020. We have received written feedback from the CCGs and HealthWatch and have incorporated any highlighted suggestions into the current draft and will use for future Quality Accounts
- There is no requirement to have an Independent Auditors Assurance Report prepared for the Directors of Southport and Ormskirk Hospitals NHS Trust on the Quality Account this year.

Recommendations

The Board is asked to **receive** and **approve** the 2019/20 Quality Account

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:**
Jo Simpson	Bridget Lees

Southport and Ormskirk Hospital NHS Trust

Quality Account Draft 2019 /2020

A précis version of this account is available on requests following feedback from members of the Healthwatch groups. Please call the Communications Department on 01704 704714.

CONTENTS

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-Complaints

3.7	Staff Recommending Organisation as a place to work *-KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months)* *-KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard1*	*Regulated information*
3.8	Friends and Family Test	*Regulated information*
3.9	VTE Venous Thromboembolism Risk Assessment	*Regulated information*
3.10	Infection Prevention and Control	*Regulated information*
3.11	Never Events and Duty of Candour	*Regulated information*
3.12	Reported patient safety incidents	*Regulated information*
3.13	Pressure ulcers (hospital acquired and community)	
3.14	Falls	

APPENDICES

Appendix 1 National Clinical Audits and National Confidential Enquiries

PART 4 ANNEX

STATEMENTS OF ASSURANCE

4.1	Sefton Healthwatch
4.2	West Lancashire CCG and Southport and Formby CCG

If you require this document in an alternative format, please contact our Communications Team on 01704 704714

DRAFT

PART 1

1.1 Statement on quality from Chief Executive on behalf of Board

Southport and Ormskirk Hospital NHS Trust is pleased to present the Quality Account for the period 1st April 2019 to 31st March 2020. This is my first quality account with the Trust and this document provides an overview of the progress made during the reporting period to the best of my knowledge. The priorities for the coming year 1st April 2020 to 31st March 2021, and includes the regulated information prescribed under the National Health Service Quality Accounts Regulations. Throughout the report we will refer to Southport and Ormskirk Hospital NHS Trust as The Trust.

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

The Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire, with one of the highest proportions of elderly residents within the country. Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk and District Hospital.

The Trust also provides sexual health services for the metropolitan borough of Sefton. The North West Regional Spinal Injuries Centre is at Southport hospital and provides specialist care for spinal patients across the North West and the Isle of Man. Services at the trust are commissioned by NHS West Lancashire and NHS Southport and Formby clinical commissioning groups.

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

I hope you enjoy reading this summary of our achievements in 2019 / 20 and the work we have done to improve quality and safety in our hospital.

Trish Armstrong-Child Chief Executive

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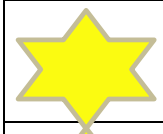
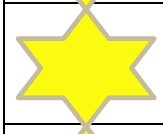
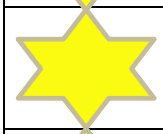
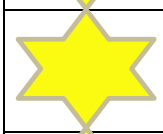
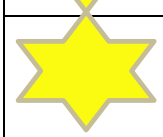
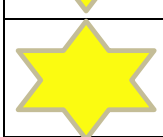
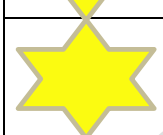
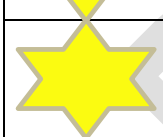
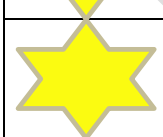
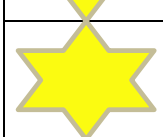
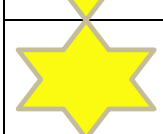
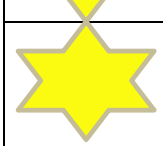
1.2 Our Quality Achievements during 2019 / 2020

	**Improvement in our national mortality measure (SHMI) indicating fewer unexpected deaths**
	**We were one of the top recruiters to the FLO-ELA research trial (**FLuid Optimisation in Emergency LAparotomy trial)
	**Launch of pets as Therapy Visits within Trust.**
	**Supported senior leadership development through running a shadow board programme for our aspiring directors.**
	**End PJ (pyjama) Paralysis introduced to the Trust – with the aim of encouraging patients to get out bed and mobilise**
	**Celebrated our quality improvements by holding quality street in December focusing on all our quality work.**
	**Recruited an admiral nurse who provides the specialist dementia support that our families need.**
	**Developed our falls strategy to plan for our work towards a decrease in the number of hospital falls and improve the care of our patients who suffer a fall.**
	**Mr Suraliwala – consultant orthopaedic surgeon - won best Musculoskeletal Principal Investigator from the Oxford Trauma Team**
	**Mr Ullah – consultant orthopaedic surgeon - won best Musculoskeletal Trainee Principal Investigator for their work on the White 5/White Cohort hip study**
	**Appointed our 24 / 7 critical care outreach team to help us identify and care for the deteriorating patient more effectively**
	**Shared our work with the community by holding an open day in Ormskirk hospital for the local community**

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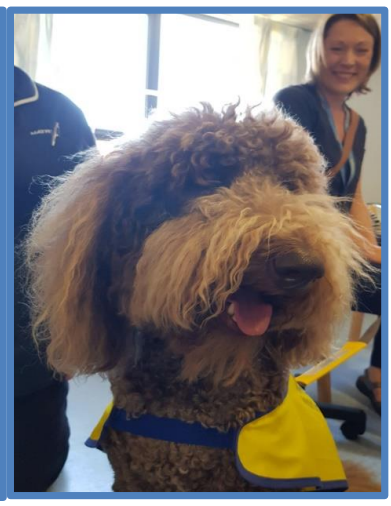
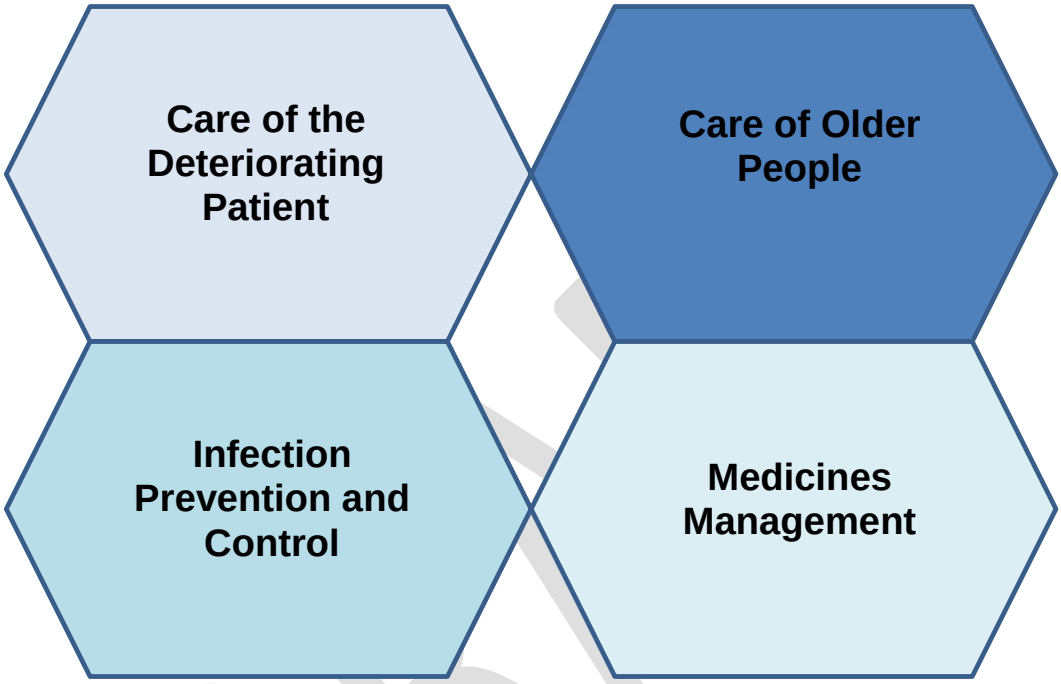
NHS
Southport and Ormskirk Hospital
Management
Teacher
Reflective
Knowledgable
Mentor
Leadership
Skilled
Role Model
Professional
Proficient
Celebration
Achievement
Progression
Appraisal
Resilience
Professional
Development
Emotional Intelligence
Team Spirit
Skills
Valued
Balanced
Sense of Belonging
Engagement
Transition
Nurture
Support
Preceptorship
Getting it right first time
For you



1.3 Review of our Priorities for Improvement 2019-20

We set 4 quality priorities in 2019 – 2020 and successful implementation is discussed throughout this quality account.



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

1.4 Care of Older People

The Older People's Care Programme has seen many quality and service improvements within the Trust, impacting on the experience of patients, their families and staff. The programme was developed on the basis of a review of previous incidents of harm, complaint themes and gaps when analysing the service provided against best practice and national guidelines. The major priorities of the programme included: care for people with dementia or delirium, falls, mouth care, deconditioning and discharge pathways, amongst other areas of focus targeted through task and finish groups.

A major development at the end of 2019 was the exciting creation of the Dementia and Delirium Team, led by our Trust Admiral Nurse. The team work across all wards working with patients, families and staff to:

- Ensure the development of comprehensive individualised care which minimised the disruption and unintended consequences of a hospital stay
- Provide advice, guidance and signposting for patients and their family to extend their support network post-discharge
- Provide training and education for staff of all levels and specific training in clinical areas

The team are progressing with plans to introduce Reminiscence Interactive Therapy Devices which provide an interactive device to play films, music, karaoke, games, photos and much more and have proven extremely effective in supporting patients with enhanced care needs and reducing falls. The team have ordered dementia friendly crockery to support patients through increasing visibility and enabling patients who may require some support to eat, to enable them and provide monthly training at Tier 2 well as creating Dementia friends in the monthly sessions that they deliver as part of the Older People's Care Programme. There are several pieces of work underway now which will develop over the coming year and have a great impact on further improving the experience of patients, their families and staff.

The HomeFirst pathways were launched, enabling patients to return home and have an assessment in their own home to determine on-going care needs. These were created in collaboration with the CCGs, local authority and the community services and are now embedded as a standard discharge pathway. These pathways have removed the need for patients to receive social assessment in the acute and unfamiliar environment for packages of support and in addition have enabled people to try at home first before decisions or assessments are made to step-up into a residential or nursing home care.

The 'Creating an Enabling Environment' project has seen a drive and focus into getting patients up, dressed and to maintain functional ability during their admission. This has focused around the international #EndpjParalysis initiative, with a visit from founder Brian Dolan to the organisation in June, 2019.

The Dietetic Team supported a piece of targeted work to determine the impact of increased visibility of the Dietetic team, providing education and training on the ward and promoting the importance of completing the MUST score. This demonstrated great impact over the three months (May, June, July 2019) improving from 56.94% to 79.41% with excellent feedback from the staff who valued the additional education and trialled various different ways to ensure that the completion of the MUST on admission and reviewing this weekly occurred as an embedded function of the ward. The Dietetic Team then utilised this information and learning to review the documentation and processes to facilitate a trust-wide improvement project under their new Team Lead.

Indicator Name	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Month Trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarter Trend	YTD 19/20
Inital MUST Assessments On Time - 10B	44.07%	56.1%	52.5%	63.89%	56.63%	64.06%	56.25%	57.81%	56.94%	65.15%	71.83%	79.41%	73.56%		57.26%	58.77%	59.9%	74.78%		67.76%
Repeated MUST Assessment within 7 Days On Time - 10B	74.36%	72.31%	89.41%	83.52%	91.15%	86.87%	79.61%	71.23%	85.15%	80.39%	70.93%	70.31%	78.87%		82.57%	86.03%	79.56%	73.3%		76.46%
Uses of Unrecordable on MUST Assessment Weight Method - 10B	34.18%	57.14%	64.8%	71.94%	86.73%	66.84%	60.2%	37.57%	48.55%	19.08%	21.97%	21.39%	20.81%		64.63%	71.26%	30.95%	21.39%		28.23%
Dominate Ward of Discharged Patients who required and had a MUST Assessment - 10B											87.95%	96.1%	96.2%					93.31%		93.31%
Pressure Ulcers - 10B SSS/SAU	0	0	0	0	0	0	0	0	0	0	0	1	0		0	0	0	1		1

Linked closely to the nutrition and hydration work, the Trust was successful in securing funding for eight members to attend Health Education England's Mouth Care Matters Programme to become train the trainers in mouth care. These members of staff consisted of a variety of professional backgrounds and returned to undertake a review of the equipment provision within the organisation as well as the assessment and care plan. The team then tested and launched the new assessment, care plan and product through a staged roll-out, with the support of the project management office. In addition to this, every member of staff on the wards during the roll-out receives training and completed a competency. Feedback from patients and staff was outstanding and an audit will be undertaken to demonstrate the impact for patients experience, nutritional intake and hydration, the incidence of Hospital Acquired Pneumonia and qualitative feedback amongst other metrics. Qualitatively, the feedback from staff, patients and families this far has been excellent and mouth care is key to supporting patients with their recovery from acute illness.

The other element of the programme was the development of the frailty model and pathway. The Trust recruited to 4 Frailty Practitioners who work alongside the Consultant Geriatricians and are undertaking advanced practice Master's programmes. The team undertake comprehensive geriatric assessments and develop person-centred care plans with specific focus on valuing patient time and receiving care in the right place due to the known risks of a hospital admission. The team links closely with the community services and have undertaken an NHS Improvement Collaborative to support increasing awareness of frailty and identification in the Emergency Department. The other work streams commenced include the trialling of continence assessment and care planning, streamlining and providing education on continence products on two wards and standardising the management of patients with spinal fractures. Overall the programme has made great progress and remains an organisational priority, the work streams and projects are to be reviewed and continue to progress in 2020/2021 with maximal focus on the outcomes and experience of our patients, their families, and our staff, in the mission to deliver excellent care for older people.

1.5 Supportive, Palliative and End of Life Care

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

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

A seven day, 9-5, Queenscourt based, Central Access Hub provides a responsive, human, contact point for patients, families, the public and health professionals alike, and administrative support for the **S&SPCS**. Queenscourt doctors also provide a 24 hour palliative medicine advice.

During July/August 2019 CQC included End of Life Care in its inspection, and a report was sent to the Trust at the end of the year. End of Life care was rated as 'good' in all domains (an improvement on the previous inspection)

1. End of Life Care

End of life care at Southport & Ormskirk NHS Trust, is of course, everybody's business and the core work of every frontline staff member in the clinical areas. Frontline staff take pride in being able to provide good care and skilled support at a very difficult time for patients and those important to them.

The organisation of Palliative and End of Life Care within the Trust is co-ordinated by the End of Life Care Strategy Steering Group which meets quarterly. The Executive End of Life Care Lead is the Director of Nursing, who was Juliette Cosgrove, now Bridget Lees since January, the Non-Executive End of Life Care Lead is Julie Gorry and Clinical Lead, Dr Karen Groves. The S&O End of Life Care Strategy is due for update & revision this coming year.

West Lancs, Southport and Formby has a population of approximately 235,000 and a higher than average elderly population. Locally 1.2% of the population die each year, which is higher than the national average of 1% There are over 100 care homes locally with approximately 3,500 beds and approximately 12% of all those who die in S&O Hospital are admitted from a care home. Over the last 10 years the proportion of local WL, S&F residents who die in hospital has reduced from 51% to 39% and the proportion who are able to be cared for and to die in their usual place of residence (which is where most people state they would prefer to be, and which may be a care home) has risen from 43% to 54% of all local deaths in 2019.

CQC reported that:-

"The trust should consider providing accessible communication aids such as pictorial to assist staff when caring for a patient with additional needs."

Each ward has a purple folder with communication aids and advice to help staff in this respect.

For 544(60%) of all those who died in hospital, dying was recognised and an individual plan for the care of those thought likely to be dying was developed with them and their family to ensure that their care needs were met, as far as possible, in accordance with their wishes and preferences. In common with previous years, approximately 7% of all those who were thought likely to be dying, improved and a new care plan was developed to meet their new needs.

The total number of people in West Lancs, Southport & Formby who expressed a preference for place of care (PPC) was 1790, 1501 of whom died during the year, and 1325 (88%) of these achieved their PPC.

In 2019/20 there was a 4% increase in the number of people recognised as approaching the last months of life, whose Gold Standards Framework (GSF) registration was prompted by the hospital rather than their GP (785). Hospital prompted GSF registrations account for approximately 47% of all those known to be GSF registered.

There has been a 4% increase in the number of deaths occurring in hospital over the last year from 873 in 2018/19 to 904 in 2019/20. Following 367 conversations about, and an offer of, a Rapid End of Life Transfer (REoLT) 133 people (c.f. 127 in 2018/19) achieved a Rapid Transfer to their preferred place of care when they were recognised to be dying, but wanted to be elsewhere.

2. Supportive Care Services - Transform Team

It is well documented in the literature that one third of all hospital inpatients are approaching the end of their lives within the year, and one in ten will die during this admission.[1] The Supportive Care Services, the **Transform Team**, for whom Louise Charnock was Hospital Clinical Lead, consists of facilitators who have a helicopter view of the hospital and community, trying to identify those patients recognised as possibly approaching the end of their lives, either prior to admission, as they are admitted, during an admission or on discharge, to ensure that their status is recognised, care is well co-ordinated, they are supported and that their time in hospital is fruitful and efficient for them. The team educate, support and empower patients, families and the staff caring for them at any stage during their admission, but particularly at times of deterioration and uncertain recovery, especially if

[1] Clarke. D. et al Imminence of death among hospital inpatients: Prevalent cohort study. Palliative Medicine. 2014; 28(6): 474-479

thought likely to be dying, to try to ensure the best possible patient and family experience at a difficult time.

In keeping with previous years, funding to enable the Transform team to continue its work into the next financial year was confirmed in March, for one year from Southport and Formby CCG. Southport and Formby residents benefit from this service although time limited funding makes it challenging to recruit to the team.

During 2019/20 the Transform Team has seen, or discussed with ward staff, approximately 1320 patients, those important to them and the staff caring for them, who are either recognised to be approaching the last months/years of life or who are recognised as likely to be dying.

As a new way of working, during this year, Transform Facilitators have followed care home residents, who have been hospital inpatients, back to the care home to ensure that the care home staff fully understand the management plan (current or anticipatory) which has returned with them, explain it thoroughly and try to clear up any questions the staff may have.

3. Specialist Palliative Care Services

The multiprofessional **Specialist Palliative Care Team,** for whom Angela McKenna is the Team Lead, provides symptom control advice, psychological and spiritual support for those with far advanced and progressive illness with complex specialist palliative care needs who are inpatients in hospital. They also provide advice and support for their families and the staff who care for them, arranging for follow up by the Community Specialist Palliative Care Services on discharge where appropriate. Working in an integrated way with the Community Specialist Palliative Care Services enables continuity of care for patients as they move between settings.

During 2019/20, there were 758 referrals, of patients in hospital, to the service, of which 632 were new referrals and the rest readmissions and referrals. Of the 758 referrals, 714 were seen, 2 had telephone contact only and 42 either died or were discharged, within hours of referral, before being seen. Of all those seen by the hospital SPC service, 284 (43%) had non-malignant disease. 706 (99%) were seen within 24 hours of referral either by specialist palliative care nurses (most of whom are prescribers) or palliative medicine doctors. 426 (60%) were discharged from the service, 344 (80%) of these, to their usual place of residence, and 10 (1%) were still hospital inpatients at the year end. 278 (39%) died in hospital. For those who died in hospital, 62% had a recorded preferred place of care, and 66% achieved it.

The SPCS MDT meets weekly to discuss all patients referred to their care and review all those who have died. This is an opportunity to review and augment the plan of care created by the team member who made the original assessment, and for those who have died, reflect briefly on the care provided leading up to death, ensure bereavement follow up has been made, review feedback and feedforward into education.

4. Carer & Family Support

Families of those recognised as likely to be dying had 24 hour access to the Oasis Room where they may wish to catch some sleep overnight or use for daytime breaks from the bedside, and although this facility was lost during the year due to pressure within the Trust, there is work ongoing to restore this area. Each individual plan for the care of those thought likely to be dying has an area for the assessment of family needs and the creation of a plan to meet those needs and support the family. The Transform Team and PCNSs are aware of family of those who are likely to be dying and provide support and a listening ear, alongside the chaplaincy team. Local schools and girl guide groups, as well as making syringe driver bags, have been hand making comfort packs to give to relatives who stay over in hospital unprepared – Transform ensure that families receive these wherever possible.

Queenscourt volunteers have now been trained to help provide some of this support for families or provide company for dying patients who may have no family. Bereavement calls are made to next of kin / carer following the death of any GSF registered patient, to offer condolences, listen to concerns and give family members a chance to feedback regarding patient and family care experience.

In continuing to look at Bereavement services a Bereavement GAP analysis was undertaken to help assess current state of Bereavement services and to develop an action plan for improving the service.

5. Spiritual Care

For those approaching the end of their lives the meaning of life often takes on a greater significance. To make sure these needs are recognised S&SPCS, alongside the generalist hospital staff, undertake a spiritual and religious needs assessment as part of the holistic assessment of patients and those important to them.

The trust also has a dedicated hospital chaplaincy team led by Rev Martin Abrams. This team welcomed a new Catholic Chaplain, Maria Parker this year. Patients and/or those important to them have access to this chaplaincy team if they so wish. The chaplaincy team lead an Annual Memorial Service in November each year, which this year was held at Cornerstone Methodist Church in Marshside.

6. Audit

Audits have taken place during the year, to demonstrate and assure of the quality of palliative and end of life care within the Trust.

a) Audits in response to the Gosport Report

In response to the Report of the Gosport Enquiry concerning the prescribing and use of opioids and syringe pumps, the S&SPCS have undertaken a number of different audits around opioid prescribing, dosage, indications and use of syringe pumps within the local area. All of the audits have demonstrated safe and proper prescribing of opioids within the trust and given the necessary assurances to the trust board and local CCG's.

b) National Audit of Care at the End of Life in Hospital (NACEL 2 AUDIT 2019)

S&O NHS Trust has taken part in each of seven biennial national audits of care of the dying in hospital, the last of which took place in 2019 and was reported in 2020. The audit included a retrospective case note review of all non-sudden hospital deaths which occurred in April & May 2019 and a quality survey sent to bereaved relatives.

Seven areas of care were reviewed and summary scores given for each theme. Where S&O NHS Trust's scores in each domain had been above the national average in the previous audit, they have sadly dropped just below the average in all domains in this audit, showing that there is room for improvement across the board. Due to differences in the data collection and questions asked it is not possible to compare these audit results with previous years.

The average age of dying (84 years) in S&O is higher than the national average (80 years) in line with the average age of the local population and the proportion of those who die in hospital who are care home residents (42%) is significantly higher than the national average (16%).

Where dying is recognised by the team caring for the patient there is documentation of the conversations with families about what is happening and the planning of care to support both patient and family practical, psychological, emotional, social and spiritual needs at the difficult time. There is less good documentation of the conversation with patients themselves, about the fact that they might be dying. There was good documentation of prescribing for, and control of, symptoms associated with dying. Documentation of hydration status, eating, drinking and mouthcare was less good - this was confirmed by an internal audit which confirmed these findings.

CQC had reported that:-

"We were concerned that at Southport hospital staff did not always monitor and reassess pain or administer additional pain relief in a timely manner." "The trust should consider conducting regular audit of the pain care plan across the hospital."

Further audits relating to pain management, monitoring and timely administration of opioid pain relief, have since been undertaken, as has work to improve the experience for patients with pain which has unfortunately been delayed due to the Covid-19 pandemic.

Relatives report feeling generally well supported during the period that the patient was dying. Two thirds reported that they had been asked about their needs and emotionally supported, although only one in four reported having been offered spiritual support by staff.

S&O NHS Trust has a full face to face Specialist Palliative Care Service seven days a week 9am-5pm (with palliative medical advice available 24 hours a day).The national care of the dying in hospital audit report confirms that this service is only offered by 53% of hospitals nationally with 47% of hospitals having a less than seven day service.

There is further work to be done in ensuring that the likelihood of dying is recognised early by the multiprofessional team, and discussed with patient and those important to them, to

ensure that all are able to be involved in developing the plan for care, and also ensuring that concerns about hydration and nutrition are elicited even when not volunteered, and discussed fully. Subsequent audits are underway.

An audit of religious and spiritual needs of patients demonstrated that, although the chaplaincy response to expressed need for support was excellent, the initial assessment of spiritual need, recording of religious affiliation and its importance to the patient, which would lead to such referrals to chaplaincy, was less robust and needs attention.

Audits of the Rapid End of Life Transfer process demonstrated significant improvement with over 90% completion of documentation in all areas and a reduction in the number of incidents relating to this process.

CQC reported that:-

"The trust should consider conducting regular audit of the syringe driver checklist across the hospital."

These syringe driver checklist audits have been ongoing for some years now and there is good assurance from the results.

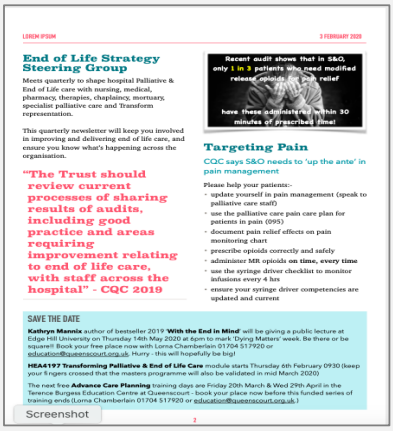
6. CQC Action Plan

The CQC Action Plan for Palliative and End of Life Care has now been completed in response to the CQC report 2019. This has resulted in a widened membership of the End of Life Strategy Steering Group, quarterly newsletter for all areas of the Trust to share lessons learned, increased education and reminders about the use of pain care plans and monitoring charts, prompts about timely administration of modified release opioids for pain relief, greater oversight of staff training in the delivery of continuous drug infusions via the subcutaneous route, reminders of where communication aids are found on each ward (purple folder), consideration of how anticipatory 'just in case' medicines are prescribed for those likely to be dying and attention to facilities for overnight stays for relatives of patients likely to be dying.

CQC reported that:-

"The trust should review current processes of sharing results of audits including good practice and areas requiring improvement relating to end of life care with all staff across the hospital."

In an attempt to improve dissemination of lessons learned, it was agreed to circulate a newsletter after each End of Life Strategy Group meeting quarterly. The first went out in February after the January strategy meeting. It was circulated electronically and in hard copy to every area of the hospital.



6. Future Care Planning

Future Care Planning is an important contribution to patient care in line with their wishes and preferences. Future Care Planning consists of two parts – Advance Care Planning (personal plans made by patients about their wishes and preferences for the future) and Anticipatory Clinical Management Planning (clinical plans made in advance by health professionals for predicted events).

In the year to which this report relates, across WL, S&F, 597 people (181 of whom have had a hospital admission during the year) have had an Advance Care Planning conversation relating to their personal wishes and preferences for their future care. 224 (38%) chose to document an advance statement of their wishes and preferences, 82 (14%) chose to make an Advance Decision to Refuse Treatment, 299 (50%) chose to appoint a Lasting Power of Attorney for health & welfare.

Anticipatory Clinical Management Plans are made by clinical staff either as a preparation for an anticipated clinical event or to try to plan care for those who may lack the capacity to make decisions for themselves. The Elderly Medicine Teams and the Transform Team help to make Anticipatory Clinical Management Plans with patients and their families to try and ensure that appropriate treatments are undertaken and inappropriate admissions avoided, as wished by the patient, especially out of hours, by teams who do not necessarily know them. Five hundred and sixty six ACMPs have been made by these teams, with WL, S&F patients and families in 2019/20.

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

The North West Coast Learning Collaborative has designed and developed an Advance Care Planning training day for frontline health and social care staff, which is being funded by Health Education England and delivered from the Terence Burgess Education Centre at Queenscourt. So far 87 Trust staff have undertaken the day's training to help them in supporting patients to discuss and make Advance Care Plans should they so wish.

7. Education

Education is a really important part of the Specialist Palliative Care role. All members of the Supportive and Specialist Palliative Care Services provide point of care education to frontline staff on an ad hoc and informal basis. Hospital staff have access to all education provided by the Terence Burgess Education Centre at Queenscourt and S&SPCS staff contribute to Trust educational events e.g. new staff induction days, Foundation Year doctors and Core Medical Trainees education programme, Staff Grade Study Days etc.

Five S&O RGNs have been supported to undertake the Queenscourt / Edge Hill University modules 'Transforming Integrated Palliative and End of Life Care' and 'Transforming End of Life Trajectories' and three should obtain their PGCert in the next year. The Masters programme has now been validated and it is hoped that some of these will join new members of staff to embark on this programme to enhance the understanding and leadership of end of life care on the wards.

8. The Covid-19 Pandemic

Although the Covid-19 pandemic, in theory belongs to next year's report and will no doubt be reported in full at that time, it would be remiss not to mention the huge palliative care response of the Trust working in collaboration with Queenscourt Supportive and Specialist Palliative Care Services to creatively care for those seriously ill and likely to die, from whatever cause, during this period.

9. Into the Future

The trust recognises the importance of good end of life care and in partnership with Queenscourt are planning an accreditation process for the hospital wards to enable demonstration of good practice.

There is also a commitment to ongoing education and development with the hope of every ward having at least one RGN having undertaken a level 7 module in End of Life Care through Edge Hill University.

The End of life Skillset challenge is still active within the trust to date 544 hospital have completed at least one level of the challenge.

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1.6 Safer Staffing

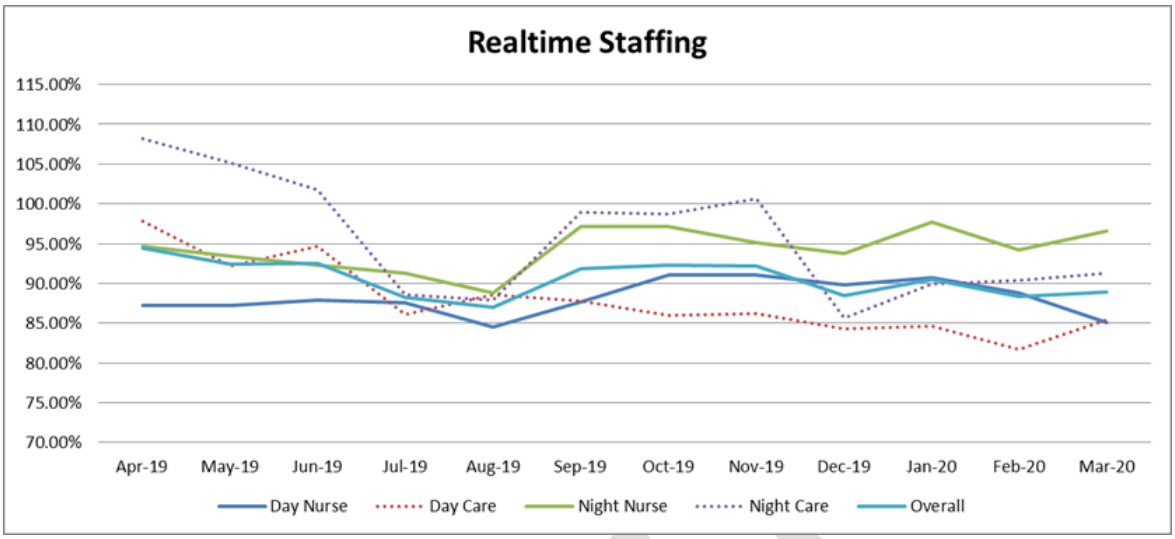
Nursing

Safe staffing levels impact on the ability of nursing and midwifery staff to provide high quality care and the Trust continues to carry a number of nursing vacancies. This is reflected in the Trust Board Assurance Framework (BAF) and the Division's Risk Registers.

Reviews of staffing numbers and skill mix will continue to be ongoing and any changes will be based on triangulation of acuity, current quality indicators and outcomes and professional judgement, whilst taking into account any available national guidance.

We have a planned approach to nursing and health care assistant (HCA) recruitment and dates are already in the calendar for the next events. There are a number of ongoing initiatives to support the trust with recruitment and retention. These include:

• Building on bespoke adverts created for wards and departments and these are used alongside rolling recruitment campaigns
• Focused work with the Ward Managers and Matrons on hard to recruit area with regard to development opportunities available
• Working with Communications and Human resources to promote the Trust as a great place to work through best use of social media; we have built a strong network of Trust nursing staff using Social Media to promote the Trust as an employer of choice
• Implementation of Rotational posts within Adult Acute and Elective Care Divisions
• The Trust acknowledges its requires to have a very strong focus on ensuring we appoint newly qualified nurses and we are actively engaging with these opportunities in communication with our local Health Education Institutes
• A review of historical student placement numbers and a proposed significant increase in student nursing training placements at the trust
• The Director of Nursing, the Deputy Director of Nursing and Assistant Director of Nursing Workforce meet now on a regular basis with nurses in training and on qualification
• In recognition of the valuable contribution of the HCA workforce a review of the Care Certificate has commenced to support our current workforce and the potential HCA pipeline
• The Care Support Worker Development (CSWD) programme run in collaboration with NHS Professionals (NHSP) has continued to support our pipeline of HCA 's
• Building on apprenticeship opportunities to nursing and Allied Health Professional roles.



The graph starts to show a decrease in fill rate for nurse staffing in March 20 reflective of the onset of COVID-19 pandemic. The reporting tools used to support planned safe nurse staffing are not aligned to the daily requirements to re-deploy staffing groups to mitigate any shortfalls and we therefore see a declining picture. This is not reflective of the Trusts response to ensuring safe staffing and during the pandemic multidisciplinary staff groups were redeployed to support clinical areas on a daily basis to ensure delivery of patient care as priority.

The vacancy levels documented below include the acute ward areas, and critical care.

Vacancy levels RN	June 19	July 19	August 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
Actual vacancy (WTE)	2.57	2.57	2.57						
Predicted Mat Leave and LTS (WTE)	19.59	20.12	21.16	9.74	7.46	6.46	6.38	5.46	5.46
Turnover (WTE)	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Net Vacancy (WTE)	**25.16**	**25.69**	**26.73**	**12.74**	**+0.54**	**9.46**	**9.38**	**8.46**	**8.46**

Vacancy levels HCA	June 19	July 19	August 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
Actual vacancy (WTE)	6.17	6.17							
Predicted Mat Leave and LTS (WTE)	11.15	10.15	17.32	18.48	18.70	16.25	16.25	15.64	15.64
Turnover (WTE)	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Net Vacancy (WTE)	**20.67**	**12.52**	**20.32**	**21.48**	**16.7**	**19.25**	**19.25**	**13.64**	**18.64**

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

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

Junior Doctor Training Position Statement reported to local negotiating committee May 2020

Specialty	Total Number of Trainee Slots	Gaps Identified
Anaesthetics	1	
Acute Internal Medicine	3	
Acute Internal Medicine	2	
Cardiology	2	
Community Sexual and Reproductive Health	1	1 x ST1
Core Anaesthetics Training	7	
Core Medical Training	15	3 x CT1
Core Surgical Training	4	
Emergency Medicine	11	
Emergency Medicine	5	
Endocrinology and Diabetes Mellitus	2	1 x ST3
Gastroenterology	2	
General (Internal) Medicine	1	
General Medicine	3	
General Practice	9	
General Psychiatry	4	
General Surgery	11	1 x ST3 due to mat leave
Geriatric Medicine	7	
Obstetrics and Gynaecology	13	1 x ST3 due to having 3 LTFT trainees
Ophthalmology	1	1 x ST3 due to mat leave
Paediatrics	12	
Rehabilitation Medicine	1	
Respiratory Medicine	4	
Rheumatology	2	
Trauma and Orthopaedic Surgery	6	2 x ST3
Urology	3	
TOTAL	133	10

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

1.7 Learning from Deaths

The Trust is committed to improving mortality and in turn mortality rates through the 'Reducing Avoidable Mortality'.

During April 2019 – March 2020, 906 of The Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
Quarter 1- 221
Quarter 2 - 174
Quarter 3 - 258
Quarter 4 – 253

In relation to the 906 deaths, 594 case record reviews were undertaken which resulted in 166 structured judgement reviews being carried out and *3* investigations in relation to *3* deaths reported.

**following review at the Trust's Serious Incident Review Group, one of these deaths was deemed to not require further investigation.*

Structure judgement reviews are undertaken when the initial case record review identifies areas of concern which require a more detailed case note review.

Following the structured judgement review if the death is deemed avoidable or serious lapses in care are identified a full incident investigation will be trigged.

In *2* cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was
Quarter 1 – 0
Quarter 2 – 0
Quarter 3 – 1
Quarter 4 - 1

2 representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
-0 representing the 0% of the number of deaths which occurred in quarter 1
-0 representing the 0% of the number of deaths which occurred in quarter 2
-1 representing the 0.4% of the number of deaths which occurred in quarter 3
-1 representing the 0.4% of the number of deaths which occurred in quarter 4

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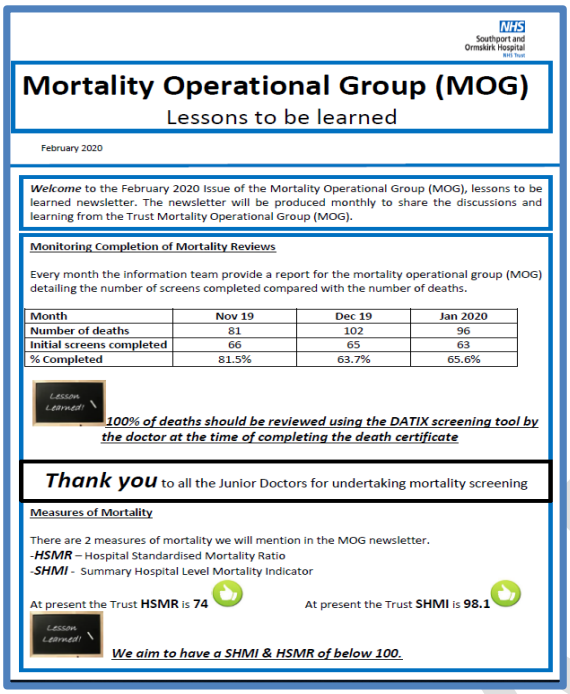
Learning from Deaths - Monthly newsletter produced to share information.



NHS
Southport and Ormskirk Hospital NHS Trust

Mortality Operational Group (MOG)

Lessons to be learned

February 2020

Welcome to the February 2020 Issue of the Mortality Operational Group (MOG), lessons to be learned newsletter. The newsletter will be produced monthly to share the discussions and learning from the Trust Mortality Operational Group (MOG).

Monitoring Completion of Mortality Reviews

Every month the information team provide a report for the mortality operational group (MOG) detailing the number of screens completed compared with the number of deaths.

Month	Nov 19	Dec 19	Jan 2020
Number of deaths	81	102	96
Initial screens completed	66	65	63
% Completed	81.5%	63.7%	65.6%

Lesson Learned!

100% of deaths should be reviewed using the DATIX screening tool by the doctor at the time of completing the death certificate

Thank you to all the Junior Doctors for undertaking mortality screening

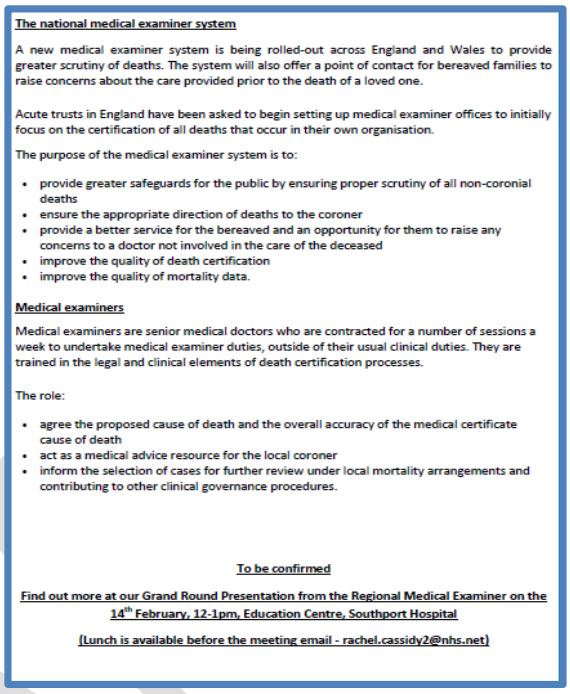
Measures of Mortality

There are 2 measures of mortality we will mention in the MOG newsletter.
-***HSMR*** – Hospital Standardised Mortality Ratio
-***SHMI*** - Summary Hospital Level Mortality Indicator

At present the Trust **HSMR** is **74** At present the Trust **SHMI** is **98.1**

Lesson Learned!

We aim to have a SHMI & HSMR of below 100.



The national medical examiner system

A new medical examiner system is being rolled-out across England and Wales to provide greater scrutiny of deaths. The system will also offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one.

Acute trusts in England have been asked to begin setting up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

Medical examiners

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

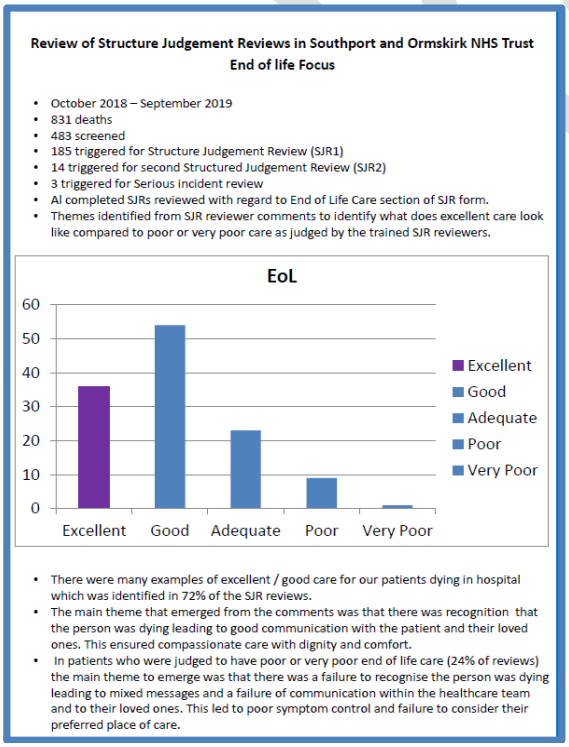
The role:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures.

To be confirmed

Find out more at our Grand Round Presentation from the Regional Medical Examiner on the 14th February, 12-1pm, Education Centre, Southport Hospital

(Lunch is available before the meeting email - rachel.cassidy2@nhs.net)



Review of Structure Judgement Reviews in Southport and Ormskirk NHS Trust
End of life Focus

- October 2018 – September 2019
- 831 deaths
- 483 screened
- 185 triggered for Structure Judgement Review (SJR1)
- 14 triggered for second Structured Judgement Review (SJR2)
- 3 triggered for Serious incident review
- Al completed SJRs reviewed with regard to End of Life Care section of SJR form.
- Themes identified from SJR reviewer comments to identify what does excellent care look like compared to poor or very poor care as judged by the trained SJR reviewers.

- There were many examples of excellent / good care for our patients dying in hospital which was identified in 72% of the SJR reviews.
- The main theme that emerged from the comments was that there was recognition that the person was dying leading to good communication with the patient and their loved ones. This ensured compassionate care with dignity and comfort.
- In patients who were judged to have poor or very poor end of life care (24% of reviews) the main theme to emerge was that there was a failure to recognise the person was dying leading to mixed messages and a failure of communication within the healthcare team and to their loved ones. This led to poor symptom control and failure to consider their preferred place of care.

Some of our Staff

People's Voted Award - HALT Team

1.8 Implementing priority clinical standards for seven-day hospital services

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

The objective of the Seven Day Services (7DS) programme is to ensure that patients, who are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. The requirement has been for seven day consultant-led services to deliver this requirement with the original deadline of March 2020.

Our progress with implementing seven day services has been assessed as guided by the Seven Day Services Board Assurance Framework. Our most recent submission to the Trust board using the self-assessment tool was in February 2020.

The following items below were highlighted as Must / Should Do Actions for 7DS service in the Trust's CQC Inspection Report 2019 and will be included in the Action Plan.

Core Service	Must Do / Should Do	Area for improvement
Children & Young People	Must Do	The trust must ensure that every child is seen by a consultant paediatrician within 14 hours
Critical Care	Should Do	The trust should ensure that consultant ward rounds are consistently completed twice a day during weekends.
Critical Care	Should Do	The trust should improve seven-day service provision to provide more continuity of care for patients and maintain national standards.
Trust Wide	Should Do	The trust should consider improving child and adolescent mental health services provision to a seven-day service.

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Current Self-Assessment Position

Clinical Standard 1: PATIENT EXPERIENCE Shared decision making and informed choices for families and carers 7/7	Progress Ongoing
Clinical Standard 2: 14 HOUR REVIEW All Emergency Admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest, within 14 hours of admission to hospital	Progress Ongoing
Clinical Standard 3: MDT REVIEW 14 hour assessment by MDT for emergency in-patients. An integrated management plan with EDD and medicines reconciliation within 24 hours	Progress Ongoing
Clinical Standard 4: SHIFT HANDOVERS Handovers by a senior decision maker at designated time and place. Handover processes including communication & documentation requirements formalised in a policy.	Progress Ongoing
Clinical Standard 5: ACCESS TO DIAGNOSTIC SERVICES Hospital inpatients must have scheduled access to diagnostic services such as X-ray, Ultrasound, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Echocardiography, Endoscopy, Bronchoscopy and pathology seven days a week. Consultant-directed diagnostic tests and completed reporting must also be available seven days a week: Within 1 hour for critical patients, Within 12 hours for urgent patients, Within 24 hours for non-urgent patients	Progress Ongoing
Clinical Standard 6: CONSULTANT DIRECTED INTERVENTIONS Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: Critical care, Interventional radiology, Interventional endoscopy, Emergency general surgery.	Achieved
Clinical Standard 7: MENTAL HEALTH Mental health needs identified for acute admissions to be assessed by psychiatric liaison within 1 hour for emergency care and 14 hours for urgent care 7/7	Progress Ongoing
Clinical Standard 8: ONGOING REVIEW IN HIGH DEPENDENCY AREAS All patients on the Acute Medical Unit, Acute Surgical Assessment Unit, Intensive Therapy Unit and other high dependency areas are seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Progress Ongoing
Clinical Standard 9: TRANSFER TO COMMUNITY, PRIMARY & SOCIAL CARE Support services to be available 7/7 to ensure next steps for patient care are consultant led whether in hospital, community or mental health setting.	Progress Ongoing
Clinical Standard 10: QUALITY IMPROVEMENT All those involved in delivery of acute care to be involved in the review of patient outcomes to drive care quality improvement	Progress Ongoing

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1.9 Freedom to Speak Up

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

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

Martin Abrams, Freedom to Speak Up Guardian
Freedom to Speak Up Champions
Bridget Lees, Director of Nursing
Trisha Armstrong-Childs, Chief Executive - Straight to Silas
Pauline Gibson, Non-Executive Board Lead with responsibility for raising concerns

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

How feedback is given to those who speak up

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

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

A persons concern can be anonymous or can remain confidential.

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

The Trust also has an Equality and Diversity Lead.

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

Team of the Year Award - Stroke Ward

1.12 Statement of Responsibilities from Board of Directors

Will be updated once the report is approved by Board in December 2020

Southport & Ormskirk Hospital NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) regulations to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board

Chairman	December 2020
Chief Executive	December 2020

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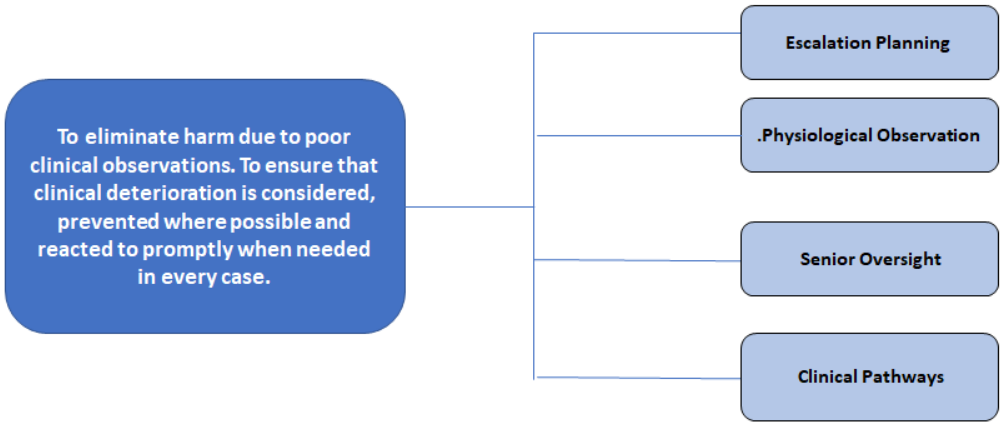
PART 2

2.1 Priorities for Improvement 2020- 2021

We had planned to arrange focus groups with our local population to involve them in identifying our priorities for 2020 / 2021. Unfortunately due to COVID 19 pandemic this was put on hold to prevent the spread of the virus. Therefore our priorities remain unchanged.

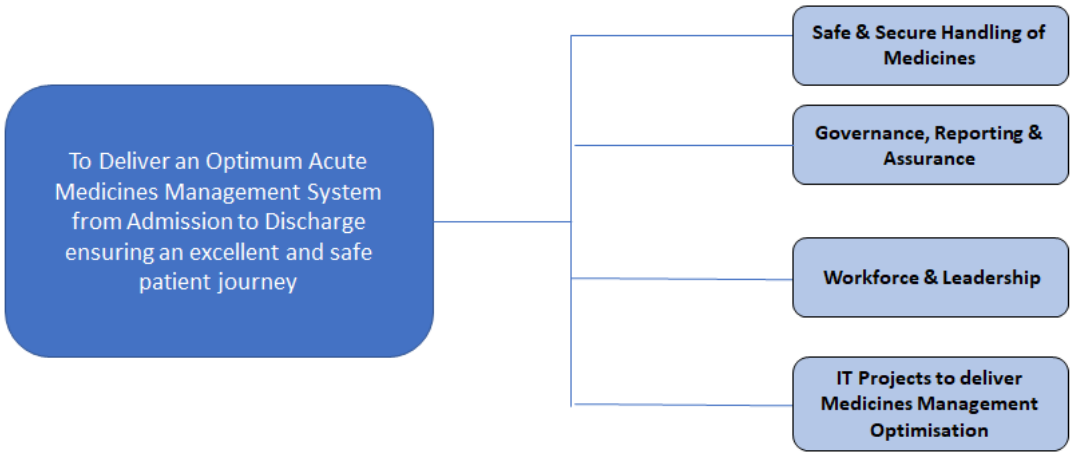
Recognition & Care of the Deteriorating Patient Programme

Aim - To eliminate harm due to poor clinical observations, to ensure that clinical deterioration is considered, prevented where possible and reacted to promptly when needed in every case.



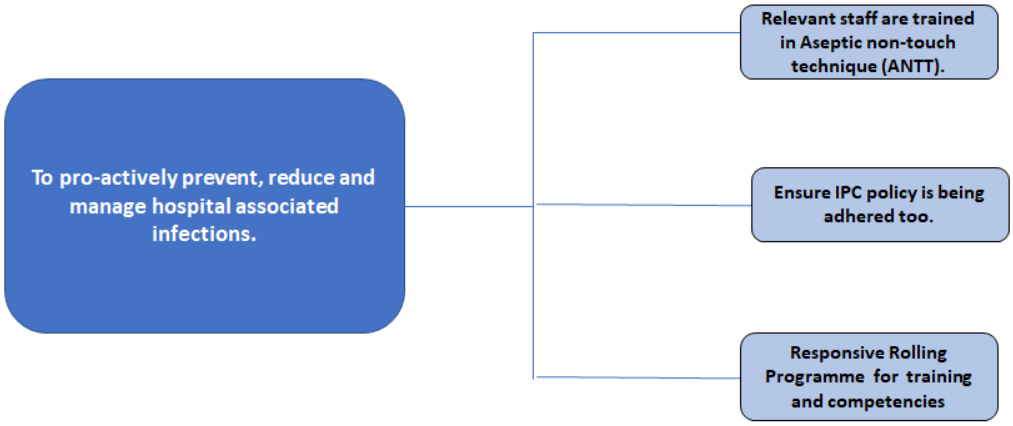
Medicines Management Optimisation Programme

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



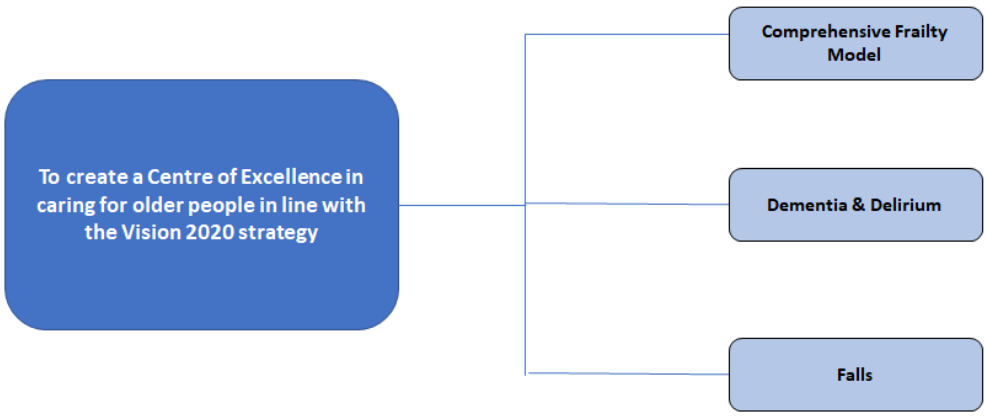
Infection Prevention Control Programme

Aim – To proactively prevent, reduce and manage hospital associated infections.



Care of Older People Programme

Aim – To create a Centre of Excellence in caring for older people in line with the Vision 2020 strategy



2.2 Review of Services

Statements of Assurance from the Board (in regulations)

During April 2019 and March 2020 the Trust provided 3 relevant health services:
-acute hospital
-paediatric
-sexual health community based

The NHS services are made up of the following regulated activities for which the Trust became registered with the Care Quality Commission (CQC) without conditions from April 2010:

- Treatment of diseases, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Maternity and Midwifery services
- Termination of pregnancies
- Assessment or medical treatment for persons detained under 1983 Mental Health Act
- Family planning

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

The income generated by the relevant health services reviewed in the period April 2019-March 2020 represents 90% of the total income generated from the provision of relevant health services by the Trust for April 2019 -March 2020.

2.3 Participation in Clinical Audit - April 2019-March 2020

During the period April 2019 – March 2020 44 National Clinical Audits and 2 National Confidential Enquires covered relevant health services that the Trust provides

During that period the Trust participated in 100% of the National Clinical Audits and 100% of the National Confidential Enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in can be found in **Appendix 1**

The reports of 44 national clinical audits were reviewed by the provider in April 2019 – March 2020 and The Trust intends to take the following actions to improve the quality of healthcare provided.
-Improve documentation of nicotine replacement provided on inpatient wards
-Increase documentation of patients who are reviewed by lung cancer nurse
-Continue to improve data collection and inputting for MINAP and the national heart failure audit
-Introduced a delirium screening tool

The reports of 227 local clinical audits were reviewed by the provider in April 2019 – March 2020 and The Trust intends to take the following actions to improve the quality of healthcare provided. (Please refer to section 2.1)

-227 audit projects were completed during 2019 / 2020
-22 projects were no longer required
-119 projects were carried over for completion in 2020 / 2021.
A slightly higher number of projects were carried over this year (32%) as opposed to 26% in the previous year which can be attributed to the COVID 19 pandemic occurring at the beginning of March 2020 and the majority of audit activity stopping.

Trustwide (Nursing, End of Life, Safeguarding)

	Number	%
Number of Audits on Trust Audit Forward Plan	**42**	
Number of projects no longer required	5	12%
Number of projects carried over to 2020 / 2021	8	19%
Number of projects completed	29	69%

Planned Care

	Number	%
Number of Audits on Trust Audit Forward Plan	**131**	
Number of projects no longer required	11	8%
Number of projects carried over to 2020 / 2021	53	40%
Number of projects completed	67	52%

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Specialist Services (Pharmacy, Radiology, Cancer Services, Blood Transfusion)

	Number	%
Number of Audits on Trust Audit Forward Plan	**130**	
Number of projects no longer required	2	1.5%
Number of projects carried over to 2020 / 2021	44	34%
Number of projects completed	84	65%

Urgent Care

	Number	%
Number of Audits on Trust Audit Forward Plan	**65**	
Number of projects no longer required	4	6%
Number of projects carried over to 2020 / 2021	14	22%
Number of projects completed	47	72%

Improvement and changes made following National Clinical Audit Projects

National Bowel Cancer Audit (01/05/2020)

-2 metrics above expectation

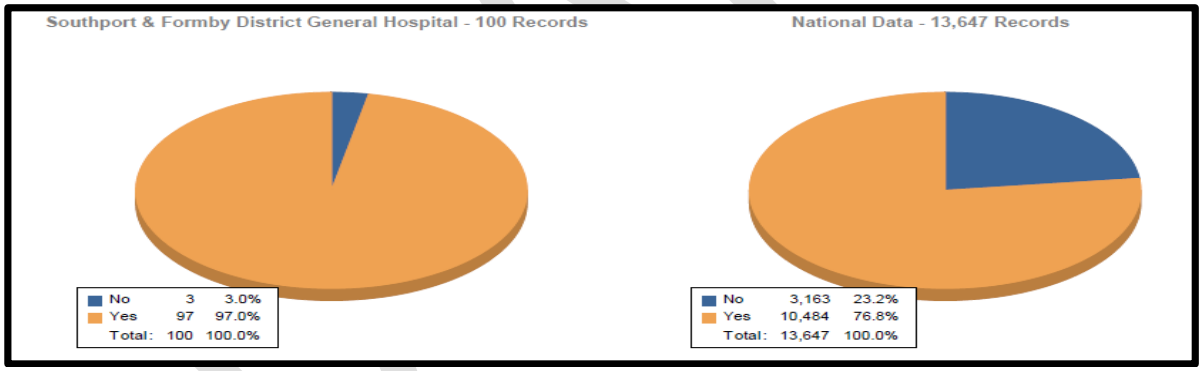
-4 metrics within expected levels

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGRATE	NATIONAL STANDARD	
Case Ascertainment	110% 2018	114% 2017	Good (over 80%)	93%	None	129 admissions
Risk-adjusted post-operative length of stay after major resection >5days	77.5% 2018	80.0% 2017	Better than national aggregate	64%	None	59 admissions
Risk-adjusted 90-day post-operative mortality rate	2.1% 2018	2% 2017	0% Within Expected Range 25%	3.3%	None	84 admissions
Risk-adjusted 2-year post-operative mortality rate	13.1% 2018	21.0% 2017	0% Within Expected Range 55%	18.9%	None	71 admissions
Risk-adjusted 30-day unplanned readmission rate	9.4% 2018	6.0% 2017	0% Within Expected Range 45%	10.6%	None	74 admissions
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	53% 2018	42% 2017	0% Within Expected Range 95%	52%	None	53 admissions

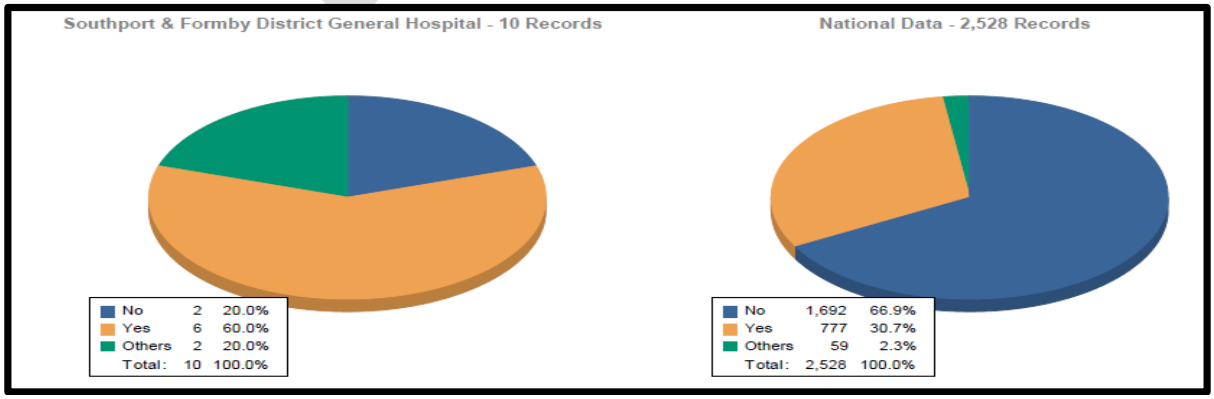
National Ophthalmology Audit (26/09/2019)
-1 measure above expectation
-2 measures NA

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGRATE	NATIONAL STANDARD	
Case ascertainment	91% 2019	64.44% 2018		N/A	None	826 Operations
Risk-adjusted posterior capsule rupture rate	0.50% 2019	48.64% 2018	0% Better Than Expected 2.1%	1.1%*	None	818 Operations
Risk-adjusted Visual Acuity Loss	Not Eligible For The Metric 2019	n/a 2018	Not Eligible For The Metric	0.9%*	None	N/A

National Audit of Smoking Cessation
Higher than national average number of patients having smoking status documented in the medical notes.



Higher than national average number of patients being offered nicotine replacement therapy.



Improvement and changes made following Local Clinical Audit Projects

Audit Project	Improvement / Change
19-099 Audit of management of Obstetric Cholestasis	Local flow chart of obstetric cholestasis to aid diagnosis and management developed. Local patient information leaflet produced to provide patients with more information regarding recurrence and pre-pregnancy counselling.
19-295 Re-audit of renal colic pathway	An alert is now on Medway to notify staff booking CTKUBs for these patients, if they have had one within the last 12 months to avoid excess exposure. Agreed multidisciplinary pathway now in use and on intranet; and hyperlink only in A&E pathway folder
19-113 Local VTE prophylaxis in outpatients with lower limb injuries with POP	An electronic form for plaster requests and a tick box for VTE assessment completed is now on Medway. Checked compliance in Nov 19, and 92% compliance
19-106 AKI prevalence in fracture neck of femur	Changes already taken place as a result of new consultant of the week system and daily review of patients enabling closer monitoring of fluid management
19-074 Neonatal Hypoglycaemia	Designated whiteboard for neonates on hypoglycaemia pathway in postnatal unit with the status of feed/BM monitoring, to be updated daily ; Paediatric staff contact number on board. Staff education on benefits of early frequent feeds for neonates at risk. Highlight BM monitoring in midwifery handovers. Train HCA staff to perform BM checks to assist midwife and escalate to midwife if hypoglycaemia. Increase number of BM machines. Standardise documentation, incorporate pathway into electronic Maternity and utilise electronic alerts as reminder. Standard method of recording patient details for handover (first name versus last name)
19-286 Audit of Hypertension management	Developed a pathway for hypertension management
19-299 Re-audit of testes pain pathway	Improved Testicular pain pathway ratified, and uploaded to new Urology pathways folder on the intranet
19-177 Procedural Sedation in Adults (care in emergency departments)	Information leaflet created and given to patients on discharge. Training sessions to be given to A&E nurses.
19-194 Junior doctor fatigue audit	Information regarding booking a room to rest in post shift is now available on the intranet.

2.4 Participation in Clinical Research

Research is built into the NHS Constitution which says that the NHS has a "commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population."

Clinical research is about improving the clinical treatments available to patients and discovering new ways of managing conditions. Southport and Ormskirk NHS Trust (SOHT) is passionate about the contribution that clinical research can make to patient care. Our engagement with clinical research demonstrates that our patients are able to gain access to the best available treatments and services, which have been rigorously tested, as well as innovative and leading edge treatments that can significantly improve health outcomes.

SOHT is a partner organisation in the Clinical Research Network, North West Coast, (CRN NWC) and works collaboratively with them to increase the opportunities for patients to take part in clinical research. We ensure that studies are carried out efficiently and meet the National Institute for Health Research (NIHR) high level objectives, which include increasing the number of patients recruited to NIHR portfolio studies.

The Trust employs a team of specialist research staff to support clinical research across the organisation and to increase recruitment to high quality clinical trials and other robust research studies.

The number of patients receiving relevant health services provided or sub-contracted by Southport and Ormskirk NHS Trust in 2019-20 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 428.

During 2019/20 the Trust was involved in 39 active studies, and the NIHR supported 36 of these, with the remaining 3 studies being local or student studies.

- The Trust has exceeded its recruitment target for the third consecutive year, which is an excellent achievement. The Trust is pleased that NIHR recruitment figures have exceeded those forecasted during 2019/20 and that the Trust successfully recruited 428 participants against the proposed target of 340. Of the 21 partner organisations in the NWC CRN, SOHT is one of only 8 Trusts to exceed the recruitment target during 2019/20.

  The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2019 the RDI department produced RDI permission (confirmation of capacity & capability) for 11 new studies of which 10 were NIHR portfolio adopted studies. This is a 22% increase (n2) from 2018/19 when 9 new studies were assessed for capacity and capability. The following table displays the specialties of the new studies:

Speciality	Number of Studies – NIHR Portfolio	Non – Portfolio
Emergency Department	4	
Paediatrics	2	
Sexual and Reproductive Health	1	
Trauma and Orthopaedics	1	
Woman and Child Health	2	
Stroke		1

Performance in initiation and delivery of research (PID data)

Performance benchmarks have been introduced by the National Institute of Health Research (NIHR) for the time taken to initiate and deliver clinical trials within the NHS. The Trust's performance against these benchmarks is published in quarterly and the reports are available at: www.Trust PID data

Commercially sponsored studies

We successfully recruited to the SWITCH1 study, a commercial study testing an investigational medicine called NT-814 as a treatment for post-menopausal symptoms. The study was well received and recruited to time and target.

Key achievements

The impact of COVID 19 on research has been immense and the Trust has responded in the most positive way. The Research team, supported by Consultants, Medics, Nurses, and support services such as Pharmacy and the Laboratories have opened a number of new NIHR Urgent Public Health Research studies at short notice. The team have worked hard to recruit to the following studies:

- ISARIC study – a study aiming to discover the background of the virus so we can try to find better ways to manage and treat the infection in the future.
- RECOVERY– a new clinical trial to test the effects of potential drug treatments for patients admitted to hospital with both suspected and confirmed COVID-19.
- GenOMICC study – a study aiming to find the genes that cause some people to be more vulnerable to COVID 19.
- UKOSS – maternal and perinatal outcomes of pandemic influenza or novel coronavirus in pregnancy.
- PAN COVID – a global registry of women with suspected COVID-19 or confirmed SARS-CoV-2 infection in pregnancy and their neonates; understanding natural history to guide treatment and prevention.

- Neonatal Complications of Coronavirus Disease (COVID-19) Study – a study collecting data about babies who have Coronavirus infection and babies whose mothers have Coronavirus infection.

Although some of the above studies opened during April 2020, and are outside the time frame for this quality account, it was deemed important to include them to highlight the response that the Trust has made in terms of research to the COVID 19 pandemic.

Working on the RECOVERY study has been a team effort, Dr Ahamed and Dr Nune stated:

"On behalf of whole recovery team, we have been privileged and greatly enjoyed being part of the recovery study during current covid-19 pandemic. Although it was a challenge at an extremely busy time, we recognised that this would offer an opportunity for our patients to receive treatment as part of the trial which otherwise they would not have had access to. This required exceptional organisation and coordination for which we are very thankful to our Research nurses Anna Morris and Moira Morrison, as without them this would not have been possible. The junior doctors associated with the study had an excellent experience of clinical research which will hopefully encourage them to engage with studies in future".

During 2019/20 SOHT were recognised as a top recruiting site for the following studies:

- FLOELA study (A clinical trial of blood flow optimisation for patients who have emergency bowel surgery).
- In January 2020 for the WHITE Cohort study, (A Comprehensive Cohort Study of Patients with Fracture of the Proximal Femur).
- In February 2020 SOHT were the first site in the country to recruit the first patient to the PEAT study (Exploring the extent to which models of 'teachable moments' explain eating behaviour in pregnancy: A longitudinal prospective study) and continue to be one of the highest recruiting sites, they recruited
- Congratulations to our Orthopaedic Surgeons Mr Krushroo Suraliwala and Mr Imran Ullah who were winners of the National Institute for Health Research 2019 Network awards. They were named best Musculoskeletal Trauma Principal Investigator and Best Musculoskeletal Trauma Trainee Principal Investigator respectively. They were involved in the multi-centre research projects WHITE 5 and WHITE Cohort; these projects have the potential to alter NICE guidelines for patients with hip fractures. The orthopaedic team were supported by the Research Nurses and the Research Support Officer.

The success of this is due to team work, including setting recruitment strategies/goals and clarifying responsibilities for each member of the team.

- SOHT have performed well against the National Institute for Health Research (NIHR) High Level Objectives (HLOs). The dedicated Research Teams at SOHT have made an outstanding contribution to recruiting participants to National Institute for Health Research (NIHR) studies. They have achieved all of the Clinical Research Network, North West Coast performance metrics, which is a fantastic achievement and places SOHT as one of the best perfoming Trusts in the CRN NWC. They have helped to increase opportunities for patients to take part in clinical research thus allowing our patients to benefit from new and better treatments.

Southport and Ormskirk NHS Trust – Perfomance against NIHR High Level Objectives:

HLO	Definition	SOHT Performance	CRN NWC Coast (all Trusts n=21)
HLO1	Number of participants recruited to NIHR trials	Target = 320 Achieved =428	8 of the 21 Trusts including SOHT met the recruitment target
HLO 2a	Number of commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	100%	53%
HLO 2b	Number of non- commercial studies achieving or surpassing their recruitment target during their planned recruitment period.	100%	63%
HLO 9a	HLO 9a Median set up time for commercial contract studies, at confirmed CRN sites (days). Site selected to first patient recruited - ambition target of 80day.	100%	46%
HLO 9b	HLO 9b Median set up time for non-commercial contract studies, at confirmed CRN sites (days). Site selected to first patient recruited - ambition target of 62days	100%	46%

- The NIHR want to understand more about patient experience of clinical research taking placing in the NHS, therefore SOHT have increased and promoted Research to both staff and patients. In particular we have made a significant contribution to the NWC CRN Patient Research Experience Survey (PRES). Since April 2019 the PRES has been recognised as one the NIHR HLOs and at SOHT we continued to support this important initiative.

- SOHT have continued to promote Research and Innovation to staff and patients via:
  - Social media, and regularly posting good new stories on the STHK Facebook and Twitter
  - Library Services
  - Training and Education

- International Clinical Trials Day (iCTD) is an annual event that takes place on the 20th May where we raise awareness of clinical trials to encourage patients, carers and the public to get involved in research. We also celebrate our achievements and take time to be grateful for the improvements made to public health. In May 2019, the research team celebrated with a stall promoting the campaign.

These achievements are only possible because of the continued support from the committed consultants, who take the role of Chief and Principal Investigators, the Research Nurses, Research Administrative teams, support services and, most importantly, the patients, who give up their time to take part in clinical trials.

Research aims for 2020-21

- Increase our Research Nurse Workforce. Research at the Trust has grown exponentially over recent years; therefore more support is required for the delivery of important research. We intend to increase the research workforce, by submitting business cases to the CRN NWC for additional income when opportunities arise.

- Strive to qualify for the minimum £20k DOH Research Capability Funding (recruiting 500 or more participants to non-commercial research).

- Explore opportunities for dedicated research appointments, including clinical academic posts, in order to address clinically relevant research questions for the benefit of our patients.

- Deliver more NIHR studies, we will involve Doctors in training as Associate Principal Investigators and encourage Research Nurses to take on the role of Principal Investigators for low risk, non- interventional studies.

- Develop partnerships with other local academic organisations, including John Moore's University, and in particular Edge Hill University. Edge Hill have recently opened a new Medical School that is one of only three new free-standing medical schools in the country, and the only one in the North West, the undergraduate programme complementing the University's well-established postgraduate medical degrees. These partnerships will allow us to seek out the best academic expertise to work with our staff and patients wherever possible to ensure that our patients benefit from world-class research

- Ensure that we build on existing strengths and key areas of current research, as well as supporting developments in other health priority areas.
- Continue to work in partnership with the CRN NWC to ensure that the NIHR high level objectives are met.
- Maintain the quality of research undertaken at SOHT by introducing and adapting to new systems and processes.
- Promote and increase engagement in Trust research by raising awareness of research activities amongst all staff and patients.

2.5 Goals agreed with commissioner's use of CQUIN payment framework

A proportion of The Trusts income in April 2019 – March 2020 was conditional on achieving quality improvement and innovation goals agreed between The Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details on the agreed goals for April 2019 – March 2020 and for the following 12-month period are available electronically at – Link to further CQUIN information.

Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment	**Fully achieved**
Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines	**Fully achieved**
Achieving 80% uptake of flu vaccinations by frontline clinical staff	**Fully achieved**
Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	**Fully achieved**
Achieving 90% of identified smokers given brief advice	**Fully achieved**
Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral	**Fully achieved**
Achieving 80% of older inpatients receiving key falls prevention actions	**Fully achieved**

2.6 What others say about us: statements from the CQC

The Trust is required to register with the CQC under section 10 of the Health and Social Care Act 2008(c).

Southport and Ormskirk Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is requires improvement.

The Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Southport and Ormskirk Hospitals NHS Trust during April 2019– March 2020.

The last Trust inspection was on the 9th July to 22nd August 2019 and the final report was published on the 29th November 2019.

Overall Trust ratings

Safe	**Requires Improvement**
Effective	**Requires Improvement**
Caring	**Good**
Responsive	**Requires Improvement**
Well-led	**Requires Improvement**

Southport and Formby hospital

Overall rating for this hospital	**Requires Improvement**
Urgent and emergency services	**Requires Improvement**
Regional spinal injuries unit	**Requires Improvement**
Medical care (including older people's care)	**Requires Improvement**
Surgery	**Required Improvement**
Critical care	**Good**
Outpatients and diagnostic imaging	**Good**
End of Life	**Good**

Ormskirk hospital

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	**Good**
Surgery	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Services for children and young people	**Good**
Outpatients and diagnostic imaging	**Good**

Community Health Services

Community Sexual Health Services	**Good**

2.7 Data quality: relevance of data quality and action to improve data quality

The Trust will be taking the following actions to improve data quality:
-establish a data quality working group
-a programme of work aimed at improving data quality
-focussed on reviewing and improving data captured within the Trust's Electronic Patient Records (EPR) including A&E, Maternity and Joint Health.

Data quality is routinely monitored throughout the Trust, this is done through a number of areas including internal data quality reports from the Trust's data warehouse and external sources such as NHS Digital and Dr Foster. These monitor improvement for a number of key fields over the different Commissioning Data Sets, they assess our organisation's data being sent externally to ensure completeness and compliance with data standards and also allow us to compare against other organisations regionally and nationally.

2.8 NHS number and general medical practice code validity

The Trust submitted records during April 2019 – March 2020 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data.

Which included the patient's valid NHS number was:

- 97% for admitted patient care
- 99% for outpatient care
- 98% for accident and emergency care

Which included the patient's valid general medical practice code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

2.9 NHS Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they have been practising good data security and that personal information is handled correctly. We submitted all 116 mandatory items, which met the required standard for 2020/2021.

2.10 Clinical Coding Error Rate

Clinical data must be accurately and consistently recorded to well defined national standards to enable it to be used for statistical analysis. Information drawn from accurate clinical coding better reflects the pattern of practice of clinicians and provides a sound basis for the decision-making process.

The audit was based on the methodology detailed in the current version 13.0 of the Clinical Coding Audit Methodology as set out by the Health and Social Care Information Centre using Clinical Classifications Service approved clinical coding auditors.

The aim of the audit was to evaluate the quality of the coded clinical data by making comparisons between the source document and the information held on the Trust's Patient Administration System (PAS) and to establish a baseline for continuous improvement and allow assessment of the quality of the source document.

The audit would identify good practice, any areas of weakness and provide recommendations as necessary to ensure that the quality of data is maintained and improved. The areas for the audit were identified by the CCGs (pneumonia, acute cerebrovascular disease and gastroenterology).

The audit was carried out by two Clinical Classifications Service approved experienced auditors from Blackpool Teaching Hospitals NHS Foundation Trust. The results of the audit were:

Total Audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	82.38	87.13	94.59	92.68
Acute Kidney Injury	95.71	91.71	93.33	100.00
Lower Respiratory Chest Infection	78.57	77.10	100.00	62.50
Pneumonia	72.86	87.55	93.33	91.18

Actions for Improvement

The Trust is fully supportive of the training requirements of the coding team. Mandatory training is up to date and all the coders have attended speciality workshops. Attaining Accredited Clinical Coder (ACC) status is encouraged and supported by the Trust
The accommodation provided for the Clinical Coders at the Southport site means there is no centralised team and there is insufficient space to accommodate the Clinical Engagement Manager.
Implementation of new Trust services is increasing the coding workload. This has been carried out without ensuring back office functions have the capacity to support innovation both now and in the future.
The Coding review processes are excellent. However Clinical Coding staffing levels

required to support these processes have not increased in line.
The source documentation is the paper case notes which have been scanned on to Evolve. A project covering documentation and the scanning of paperwork on to Evolve has commenced and is ongoing. The quality of the scanned case notes was found to be inconsistent and there is no formal scanning process in place.
An annual audit plan is undertaken, supported by Terminology and Classifications Delivery Service (TCDS) Approved Experienced Auditors as part of the Lancashire Coding Collaborative (LCC).
The Trust has employed a Medically Qualified Clinical Engagement Manager who can interpret test results, validate the coded data, answer coding staff queries and liaise with clinicians when required. There is formal clinician validation of SSNAP coded data and other ad hoc specialties.
Incorrect coding at the 3rd and 4th character level for diagnostic coding was high and highlighted a number of training issues.
In the main the discharge summary letters were available on Evolve, fully completed and contained a good level of detail. However, there was inconsistency in the recording of the diagnosis “Pneumonia” often interchanged with “Lower Respiratory Tract Infection”. Despite the availability of the Clinical Engagement Manager, there was no documented evidence that liaison had taken place.
There was a lack of consistency in the recording of diagnoses, mandatory and relevant co-morbidities, test results and interventions/procedures. Inconsistencies with Evolve makes navigation very difficult and time consuming resulting in a number of omissions from the Trusts coding.
There was no documented evidence of any liaison between coders and the Clinician or Clinical Engagement Manager to support or negate the coding of Sepsis when inconsistently documented
In the main, the coding of the interventions and procedures was done very well but on a number of occasions the standard regarding catheterisation was not followed.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

PART 3

REVIEW OF QUALITY PERFORMANCE

3.1 Performance During 2019 / 2020 on National Metrics

Indicator Name	Description	Target	Actual
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	96%	97.44%
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer.	85%	80.15%
Diagnostic waits checking	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting.	1%	10.06%
Accident & Emergency – 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission.	95%	85.38%
%Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes.	95%	52.42%
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	100%	97.8%
Duty of Candour - Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care.	100%	95.7%

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3.2 Summary Hospital Level Mortality (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is a measure used to compare the actual number of patients that have died either in hospital or within 30 days of discharge against the expected number of deaths based on average England figures, given the characteristics of the patients treated. it includes all diagnostic groups and deaths after discharge from hospital.

The data below is provided by Dr Foster on a quarterly basis using data submitted to Secondary Uses Service (SUS) so that information from all NHS Trusts in England can be taken into account. This means the data can be up to 9 months behind.

As of the July 2020 publication, COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19, and therefore excluded, is monitored in a new contextual indicator 'Percentage of provider spells with COVID-19 coding'.

Prescribed information: *The Trust considers that this data is as described for the following reasons**:** All activity data is submitted by the Trust to Secondary Uses Service (SUS) in line with national mandated requirements complying with data definitions as per the Data Dictionary*.

The Trust has taken the actions discussed in section 1.4.4 of this report to improve this indicator and so the quality of its services by focusing on mortality improvement throughout the Trust.

	Feb 2019 – Jan 2020	Jan 19 – Dec 19
Trust	101.11	99.23
Banding	2	2
Highest performing trust	67.52	68.89
Lowest performing trust	120.02	119.99

Data from NHS Digital

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

3.3 Percentage of patient deaths with palliative care coded

The Summary Hospital Level Mortality Indicator (SHMI) makes no adjustments for palliative care. The percentage of patient deaths with palliative care coding presents percentage rate of deaths that are coded with palliative care either in diagnosis or treatment specialty fields.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level	**Oct 17 - Sep 18**	**Oct 18 – Sep 19**	**Mar 19 – Feb 2020**
Trust	17%	38%	3.1%
England	18%	36%	1.9%
Highest performing trust	34%	59%	3.7%
Lowest performing trust	8%	12%	0.5%

Prescribed information (Data from NHS Digital)

Prescribed information: *The Trust considers that this data is as described for the following reasons: All activity data is submitted by the Trust to Secondary Uses Service (SUS) in line with national mandated requirements complying with data definitions as per the Data Dictionary*.

The Trust has taken the actions discussed in section 1.5 of this report to improve this indicator and so the quality of its services by focusing on mortality improvement throughout the Trust.

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3.4 Patient Reported Outcome Measures (PROMS)

Patients undergoing elective inpatient surgery hip and knee replacement funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves.

Using source data available through NHS Digital the following reports show performance based on the four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations. The PROMs results are published at least a year behind to allow for finalisation of the dataset. The figures below were published by NHS Digital for the time period 1st April 2018 – 31st March 2019.

EQ-5D-3L: Comprises of five qualitative dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has three levels: no problems, some problems, extreme problems. The respondent is asked to indicate his/her health state by ticking (or placing a cross) in the box against the most appropriate statement in each of the five dimensions. The Trust is below the national health gain for both hip replacement and knee replacement surgery.

Indicator	Source	Reporting Period	The Trust	National Average
EQ-5D adjusted health gain: Hip Replacement	NHS Digital	Apr 18 to March 19 (final)	0.348	0.465
EQ-5D adjusted health gain: Knee replacement surgery	NHS Digital	Apr 18 to March 19 (final)	0.321	0.338

EQ VAS: The EQ VAS records the respondent's self-rated health on a vertical, visual analogue scale which can be used as a quantitative measure of health outcome as judged by the individual patient: "Best imaginable health state" and "worst imaginable health state". The Trust is below the national health gain for both hip replacement and knee replacement surgery.

Indicator	Source	Reporting Period	The Trust	National Average
EQ-VAS adjusted health gain: Hip Replacement	NHS Digital	Apr 18 to March 19 (final)	6.44	14.422
EQ-VAS adjusted health gain: Knee replacement surgery	NHS Digital	Apr 18 to March 19 (final)	6.74	7.621

The Trust considers that this data is as described for the following reasons: The questionnaire use for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health.
The Trust has taken the following actions to improve this indicator and so the quality of its services, by introducing monthly reporting via the business units integrated governance reports of monthly questionnaire returns. There has been a concerted effort during 2019 / 2020 to increase the number of patients who opt in to receiving the PROMs questionnaires.

3.5 Readmissions

Readmissions are often undesirable for patients, and they can be a burden for resource-stretched NHS hospitals. Importantly, readmissions have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway including during initial hospital stays, transitional care services and post-discharge support.

Readmission rates are, however, an imperfect measure with substantial limitations. Not all reasons for readmission are under the control of the health care service or hospital, and they also are not a measure of patient preference or experience.

The percentage of patients aged 0 to 15 and 16 and over readmitted to hospital within 30 days of discharge between 1st April 2019 and 31st March 2020.

	0-15		16+		Grand Total
Apr-19	44	9.87%	402	90.13%	446
May-19	20	5.06%	375	94.94%	395
Jun-19	46	10.93%	375	89.07%	421
Jul-19	34	7.57%	415	92.43%	449
Aug-19	39	7.85%	458	92.15%	497
Sep-19	48	10.19%	423	89.81%	471
Oct-19	51	10.02%	458	89.98%	509
Nov-19	51	10.52%	434	89.48%	485
Dec-19	58	11.74%	436	88.26%	494
Jan-20	45	9.02%	454	90.98%	499
Feb-20	34	7.87%	398	92.13%	432
Mar-20	51	12.66%	352	87.34%	403
Grand Total	521		4980		5501

The Trust considers that this data is as described for the following reasons: the information is collected internally from our patient admission and discharge electronic records.

Prescribed information: The Trust intends to take the following actions to improve this indicator score, and so the quality of its services by:

-Reviewing all specialties where readmission rates are being flagged as higher than the expected rate.
-Identify where readmissions are due to complications of the previous admission.

3.6 Responsiveness to the Personal Needs of the Patient

During this year we have uplifted the Baby garden at Ormskirk Hospital was using charitable donations. The garden was formally re-opened in September as part of the Trust Open Day.

It remains open for use by staff, patients and families and is used for a regular memorial event at Christmas for those who wish to remember the baby they have sadly lost.

The policy to support Pets as Therapy was approved in June 2019 and the Trust volunteer service supported regular visits to both the Southport and Ormskirk Hospital sites.

The volunteer service supported 100 volunteers in various roles all contributing to patient and visitor experience. A new role of bleep volunteer was successfully introduced to support delivery of items to the ward/dept areas and the Southport desk volunteers were successful in winning an award in the 2019 Trust PRIDE awards.

National Inpatients Survey 2019

A questionnaire was sent to 1,250 recent inpatients at each trust.

Responses were received from 519 patients at Southport and Ormskirk Hospital NHS Trust, which is a 41.52% response rate.

The CQC represent data as below to demonstrate a comparison of positive response to questions in the survey. The higher the score the better the performance.

	2014/15	2015/16	2016 / 17	2017/2018	2018/2019	2019/2020
Trust	74.4	76.3	74.5	76.5	72.7	Has not been published yet due to Covid -19
England average	76.6	77.3	76.7	78.4	78	
Highest performing trust	87.4	88.0	88.0	87	88	

The Trust asked people to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was scored out of 10 for each question (the higher the score the better).

Each trust also received a rating of 'Better', 'About the same' or 'Worse'.

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

The Emergency / A&E department	**8.3 / 10**	About the Same
Waiting lists and planned admissions	**8.4 / 10**	About the Same
Waiting to get to a bed on a ward	**6.4 / 10**	About the Same
The hospital and ward	**7.7 / 10**	About the Same
Doctors	**8.5 / 10**	About the Same
Nurses	**7.6 / 10**	About the Same
Care and treatment	**7.8 / 10**	About the Same
Operations and procedures	**7.9 / 10**	About the Same
Leaving hospital	**6.6 / 10**	About the Same
Feedback on care and research participation	**1.1 / 10**	About the Same
Respect and Dignity	**9 / 10**	About the Same
Overall experience	**8.0 / 10**	About the Same

Prescribed information. The Trust considers that this data is as described for the following reasons: It is co-ordinated centrally for all trusts by an External source. The Trust has taken the following actions to improve this score and so the quality of its services, by the following actions:

- The Patient Experience Group monitors the results of all the patient experience questionnaires undertaken with the Trust and monitors actions taken to make improvements
- A revised patient's experience strategy has been developed and will be launched during 2020 / 20201

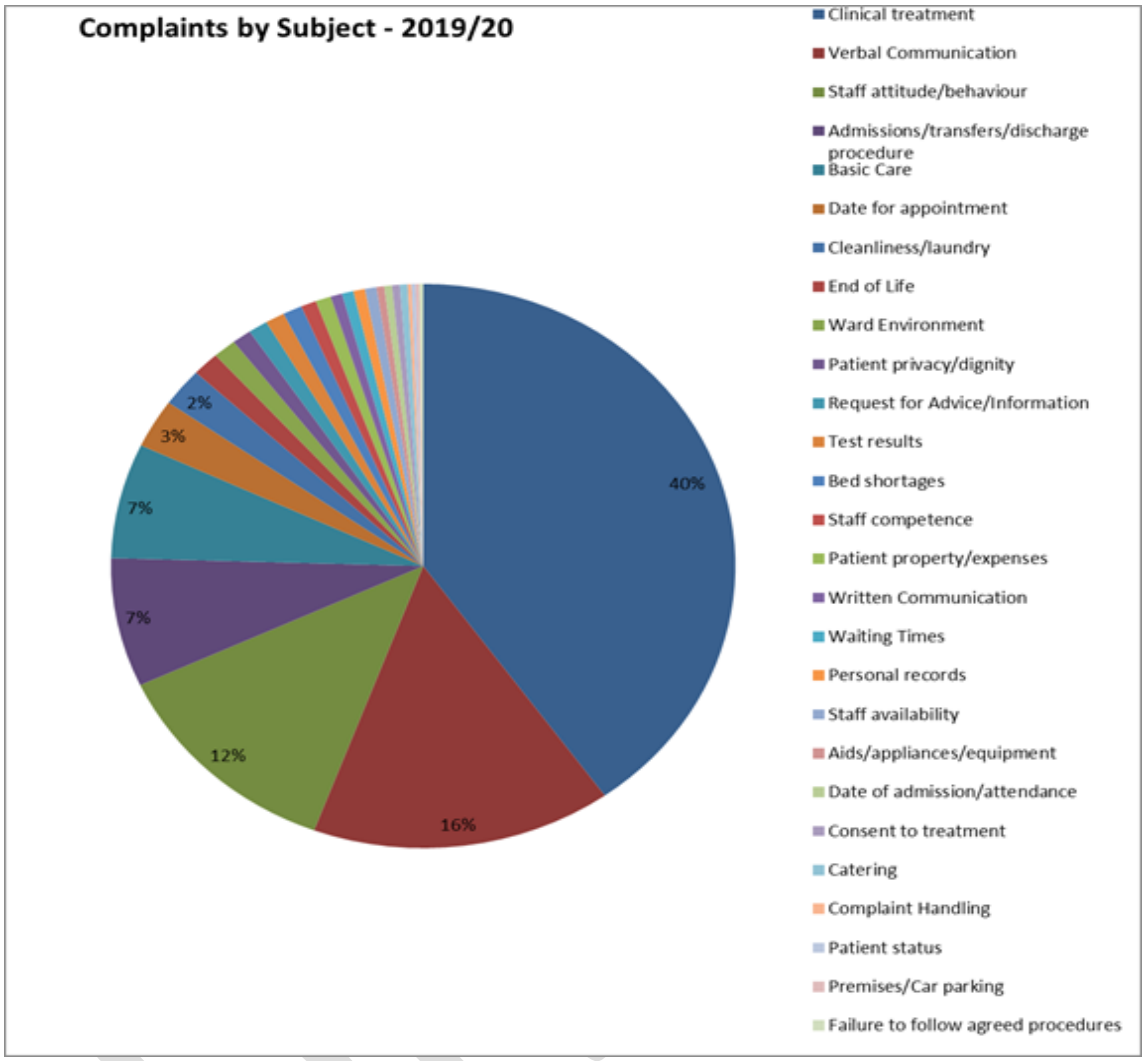
Complaints and compliments

Feedback from our patients, their families and carers give the Trust a valuable opportunity to review our services and make improvements. The Patient Experience and Complaints service is integral part of the corporate patient safety team. The Patient Experience and Complaints team act as a single point of contact for members of the public who wish to raise complaints, concerns and compliments.

The service is responsible for coordination the process and managing the responses once the investigations and updates are received from the relevant Clinical Business units. They are contactable by telephone, email, via the Trust web site, in writing or in person.

	2017/18	2018/19	2019 / 20
Formal Complaints	321	272	254
Concerns/Information Requests	429	335	606
Totals	750	607	860
Percentage change against previous year	16% decrease	19% decrease	41% increase

Complaints are a vital source of information about he views of our patients, families and carers about the quality of our services and standards of our care. Southport and Ormskirk from April 2019 to March 2020 the Trust received 254 formal complaints. There has been a 41% increase in all complaints, concerns and information requests.



Reopened Complaints

Quarter	Complaints Received	Complaints Re-Opened	% Resolved at First Response
Q1	63	7	89%
Q2	53	9	83%
Q3	69	11	84%
Q4	69	9	87%

Improvements

The lessons learnt from complaints are linked to key areas of development work and improvements across the Trust. These include

- Management of the deteriorating patient which includes timely monitoring and escalation.
- Medical records improvements and management.
- The need to develop pathways and Local Safety Standards for Invasive Procedures (LOCSIPPS), in specific areas of the Trust.
- Embedding of the review and discrepancy processes in radiology
- Improvements with medication both in the hospital and with external providers. Internally there has been a review of medicine management competencies with additional training being implemented with staff.
- Improvement to communication and documentation has been put in place with patients and their relatives, with emphasis ongoing care when the patient remains as an inpatient. Multidisciplinary team meetings have also been put in place to coordinate care going forward with full family involvement.
- Ongoing requirement to improve the standards of nursing care being received.
- A review of processes has taken place with the clinicians in Urgent Care when a patient attends with suspected cancer.
- Safety huddles twice a day have been implemented in A &E; the safety huddle includes patients who are deteriorating and those that are having problems with diet and fluids.
- Review taken place of the discharge checklist, currently does not include DNACPR as part of checklist, to be included going forward.
- Review of new agency induction processes taking place and then dissemination of processes to all permanent staff to ensure the processes are implemented when new agency staff start in a clinical area.
- Training has been put in place for the clinicians in paediatrics' regarding a missed diagnosis within paediatric outpatients department.
- Following a complaint about feeling rushed and wasting the physiotherapist time, the physiotherapy department are reviewing their communication processes.
- Review of environment and processes with parents when seeing children in the community paediatrics.
- Development of a task and finish group to focus on patient property. Following a request by the Trust, Mersey Internal Audit Authority are also currently auditing processes in relation to patients' property.
- Staff training in Abbey pain score
- Allocated nurse leads for the dementia passport
- Areas of the Trust have implemented catering assistants to provide patients with dietary support and information

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- To improve of the quality of complaint responses complaints training has been provided to key individuals within the Trust during the year, which are shared with the ward or department area.
- Timescale to answer complaints has been reduced in year so the average length of time has been brought within the 40 day target.

Parliamentary Health Service Ombudsman (PHSO) complaints

	2016/17	2017/18	2018/19	2019/20
Investigated - not upheld	3	3	1	2
Investigated - fully upheld	0	0	0	0
Investigated - partially upheld	3	3	2	1
Complaint withdrawn by PHSO	1	1	1	3
No decision made yet - carried forward	5	4	4	6
Total Number	12	11	8	12

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3.7 Staff recommending organisation as a place to work

There is an annual national survey which NHS staff are asked to complete. The Trust had 1379 staff take part in this survey during 2019. Which gave us a response rate of 47.1%%. The survey asks staff what it is like to work for the Trust and compares us nationally with other NHS Trusts.

Staff recommendation of the Trust as a place to work

Trust	Best	Average	Worst
55.1%	**78.9%**	**62.5%**	**36%**

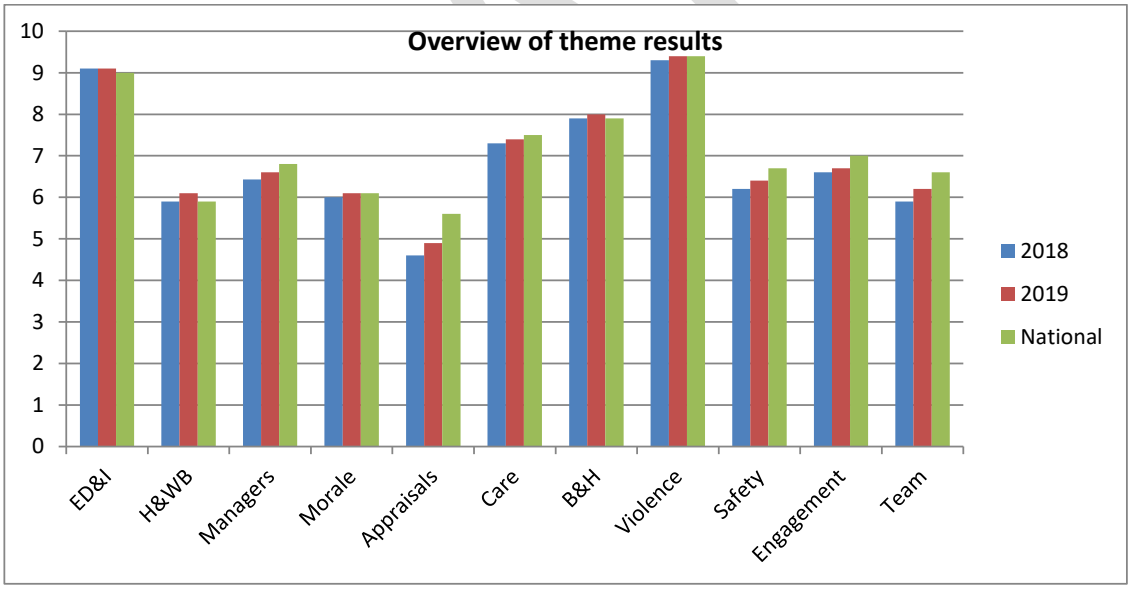
	Trust 2015	Trust 2016	Trust 2017	Trust 2018	Trust 2019
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	***54%***	***52%***	***53%***	***51.3%***	***55.4%***
Percent of staff believing the organisation provides equal opportunities for career progression / promotion	***87%***	***79%***	***79%***	***80.7%***	***82.7%***
Percent of staff experiencing harassment, bullying or abuse from staff in last 12 months	***16.8%***	***18.4%***	***19.4%***	***19.4%***	***18.7%***

Staff Experience

The Trust results have demonstrated incremental improvement in all of the themed areas below with no deteriorating scores:

- Equality Diversity and Inclusion
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement

Unfortunately despite this improvement 7 scores remain below the national average and 2 are in the bottom 20% of Acute Trusts nationally. These are Quality of Appraisals and the Staff Engagement Score. It is acknowledged that the Trust has not had any significantly improved scores over a number of years and the perception of staff is that the scores are communicated but nothing changes.



Recommendations

It is recommended that the Trust focuses on the 4 key work streams identified to drive improvement using a QI project management approach. Improvement will drive increased productivity if we have a more engaged and motivated workforce.

Next Steps

Nominate an executive lead and project lead to take forward each of the following work streams / projects. The projects will required identification of deliverables and milestones, that will make Southport and Ormskirk NHS Trust a great place to work which will ultimately result in higher staff engagement and improved productivity.

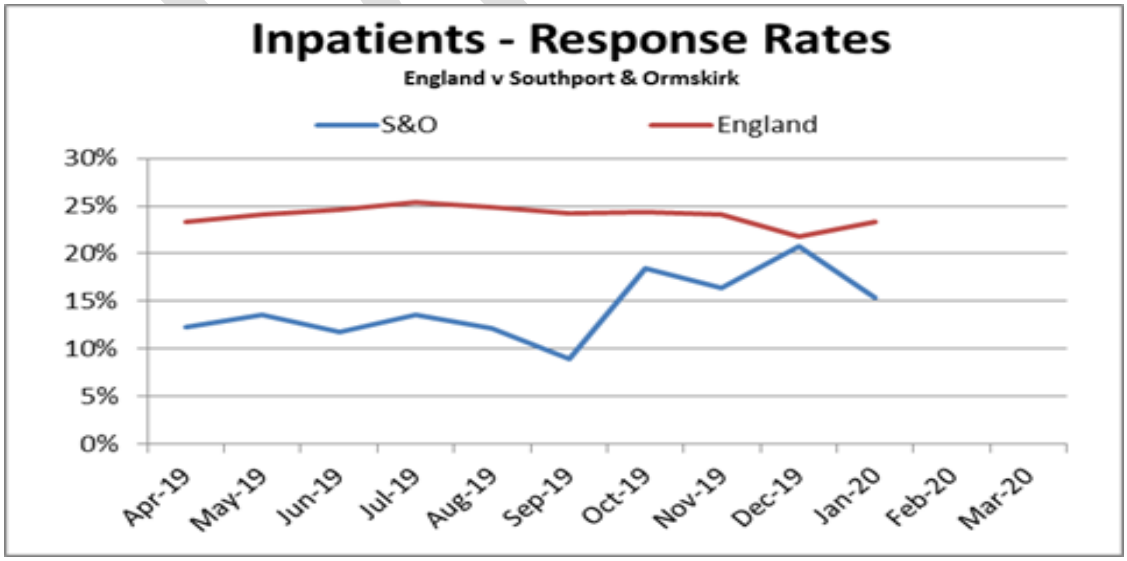
The four projects / work streams are:

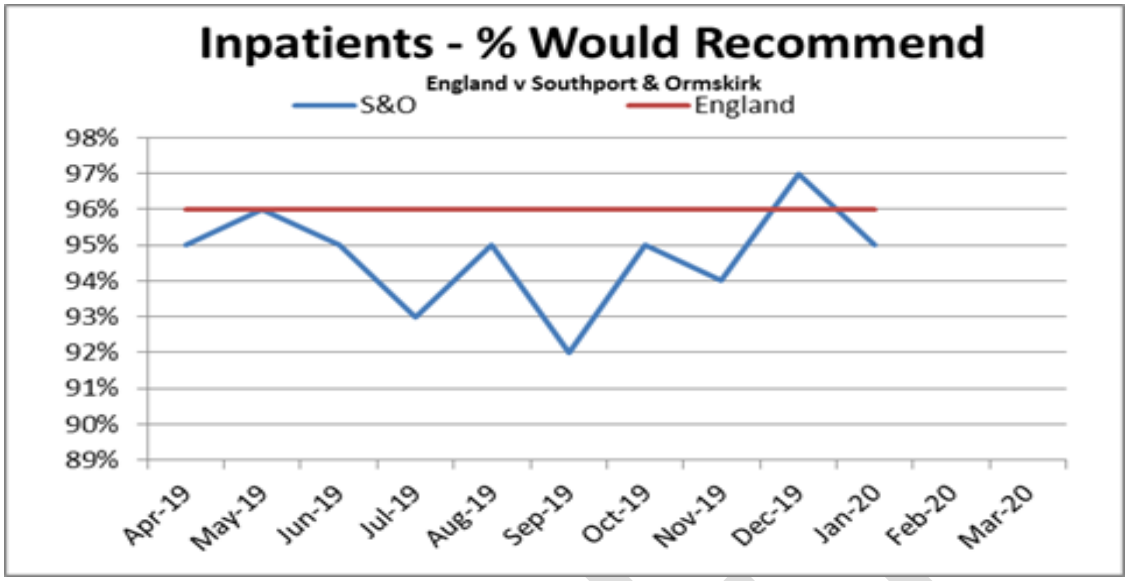
- Quality of Appraisals
- Staff Engagement
- Health and Wellbeing
- Teams and Managers

3.8 National Friends and Family Test

Patient feedback is now obtained through the implementation of the Hospedia system via the bedside screens. This system has been implemented for inpatient areas. The Friends and Family Test was a Department of Health initiative that was introduced in April 2013. The Trust was required to ask all patients the following question:

Would you recommend the hospital wards or accident and emergency unit to a friend or relative based on your treatment?' Data collection midway through the reporting year due to COVID 19





The Trust considers that this data is as described for the following reasons: response cards are collected and sent immediately back to the information team for analysis. Work is ongoing to imporove and localise patient carer and family feedback through the devloping experience of care strategy. Pledge Seven “increase the profile of patient carer andf family experiennce, collecting and acting upon feedback and opinion in a more robust manner”.

3.9 Venous Thrombo-Embolism (VTE) Risk Assessment

Prescribed information: The Trust considers that this data is as described for the following reasons: it carries out local checks to validate this data.

The VTE data collection and publication is was suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via letter on 28th March 2020

% of patients risk assessed	2019 / 2020			
	Q1	Q2	Q3	Q4
Trust	97.77%	97.96%	98%	Suspended due to COVID -19
England	95.63%	95.47%	95.33%	Suspended due to COVID -19
Highest performing trust	100.00%	100.00%	100%	Suspended due to COVID -19
Lowest performing trust	69.76%	71.72%	71.59%	Suspended due to COVID -19

Data from NHS Improvement

The Trust is pleased to be consistently above the national average. The Trust has taken the following actions to improve this percentage and thus the quality of its services:

- Embedding of root cause analysis and learning lessons
- Review process for recording incidents on DATIX
- Introduce robust process to check data accuracy

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3.10 Infection Prevention and Control

Health Care Associated Infections (HCAIs)

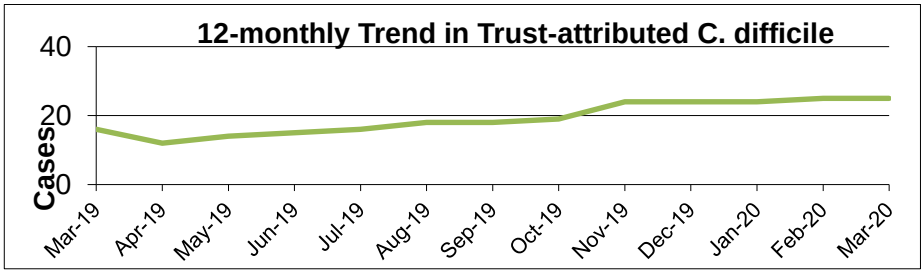
HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C. difficile) and Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia are nationally monitored as we are trying to reduce the incidence of these infections. C. difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria do not normally affect healthy people, but because some antibiotics remove the 'good bacteria' in the gut that protect against C.difficile, people on these antibiotics are at greater risk.
The MRSA bacteria are often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning. It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics.
We have a zero tolerance policy to MRSA bacteraemia infections and are working towards reducing C Difficile infections; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough.

C. difficile Infections (CDI)

The 2019-20 CDI 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.

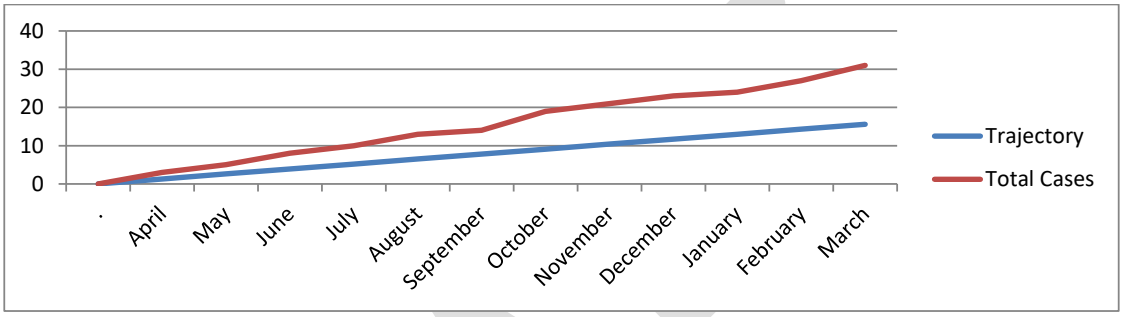


C. diff. cases against trajectory 2019/20

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.

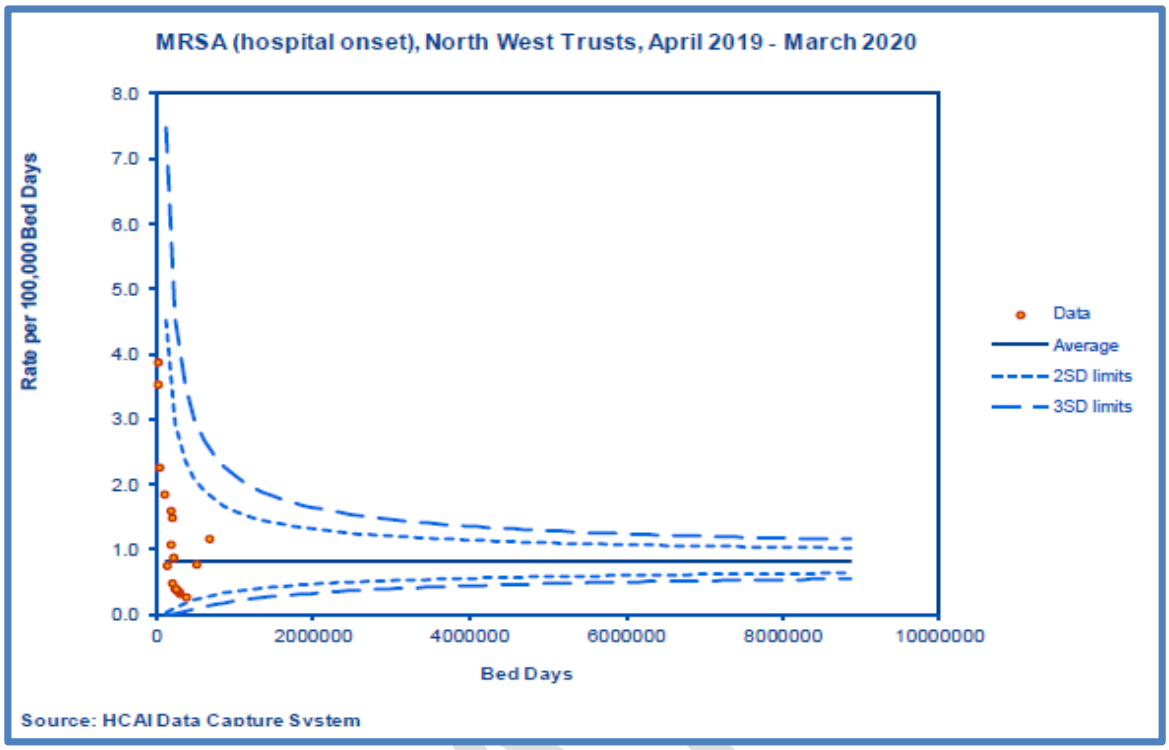
The lapses in care typically fall into two causes:

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.



MRSA Bacteraemia

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 North W average and remains a low incidence trust.



Prescribed information: The Trust considers that this data is as described due to the following reasons: all data is collected and verified by the Infection Prevention and Control Team who fully investigate each case.

C.diff rate per 100,000 bed days	2015/16	2016/17	2017/18	2018/19
Trust	26.3	15.9	15.2	12.7
England	14.9	13.2	13.7	12.2
Highest trust (Best Performing)	0	0	0	0
Lowest trust (Worst Performing	67.2	82.6	91	79.7

The Trust has taken the actions described in the previous pages to improve this rate, and so the quality of its services.

3.11 Never Events and Duty of Candour

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2019/20 1 incident was reported which met the definition of a Never Event. Thorough root cause analysis (RCA) is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence. The following table gives a description of the Never event, its primary root cause, the key recommendations to prevent reoccurrence and the level of patient harm. The patient was informed of the subsequent investigation.

Never Event Type	Description of incident and level of harm	Primary root cause	Key recommendations to prevent reoccurrence
Never Event 1	Wrong site block for shoulder surgery.	During the performance of the block, the conformation bias provided leads the anaesthetist to perform the procedure on the wrong shoulder. Lack of a formal checking process performed by the anaesthetist against the operating list or consent form prior to performance of the block.	•Stop Before You Block Posters available and displayed clearly in every anaesthetic room. • Local Safety Standard for Invasive Procedures (LocSSIP)for performing Stop Before You Block • Local Safety Standard for Invasive Procedures (LocSSIP) for surgical Site Marking • Process for the physical checking of the side and site of surgery / anaesthesia to be performed in the anaesthetic room as a part of the existing theatre sign-in procedure. •Ensure surgical site marks are made in areas that are most likely to be clearly visible to staff and exposed prior to anaesthesia. •Standardise the type of mark to be made in order for this to be as unique as possible and easily recognisable. •Refresher training for the management of regional blocks to be arranged for all ODP's

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Duty of Candour

	No of Applicable incidents	Evidence of verbal conversation / Apology within 10 days	Compliance with verbal conversation/ Apology within 10	Evidence of letter sent within 10 days	Compliance with letter send within 10 days
Q1	26	25	96.2%	25	96.2%
Q2	23	22	95.7%	22	95.7%
Q3	29	29	100%	29	100%
Q4	15	15	100%	13	86.7%
2019/20 Total	**93**	**91**	**97.8%**	**89**	**95.7%**

As the Trust knows promoting a culture of openness is a prerequisite to improving service user safety and the quality of healthcare systems. We must always apologise and explain what happened to service users who have been harmed in the course of their treatments. At the end of the year the Trust was 86.67% compliant, due to difficulty contacting a patients next of kin and issues around a bereavement. The Trust is doing the following to make improvements and ensure its meets its statutory duty 100% of the time when significant harm occurs

- deliver more training to staff so they understand the duty and their professional obligations
- continue daily monitoring
- ? is a reason NOK details not being correct?
- Implementation of a Patient Advice and Liaison Service.
- Implementation of patient safety specialists

The Trust is committed to improving communication to our patients and their families when subject to a patient safety incident.

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3.12 Reported Patient Safety Incidents

The Trust exports all patient safety incidents on an ongoing basis to the National Resource and Learning System (NRLS). Data submitted to the NRLS is published bi-annually. Increases in the number of incidents reported reflects an improved reporting culture and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.

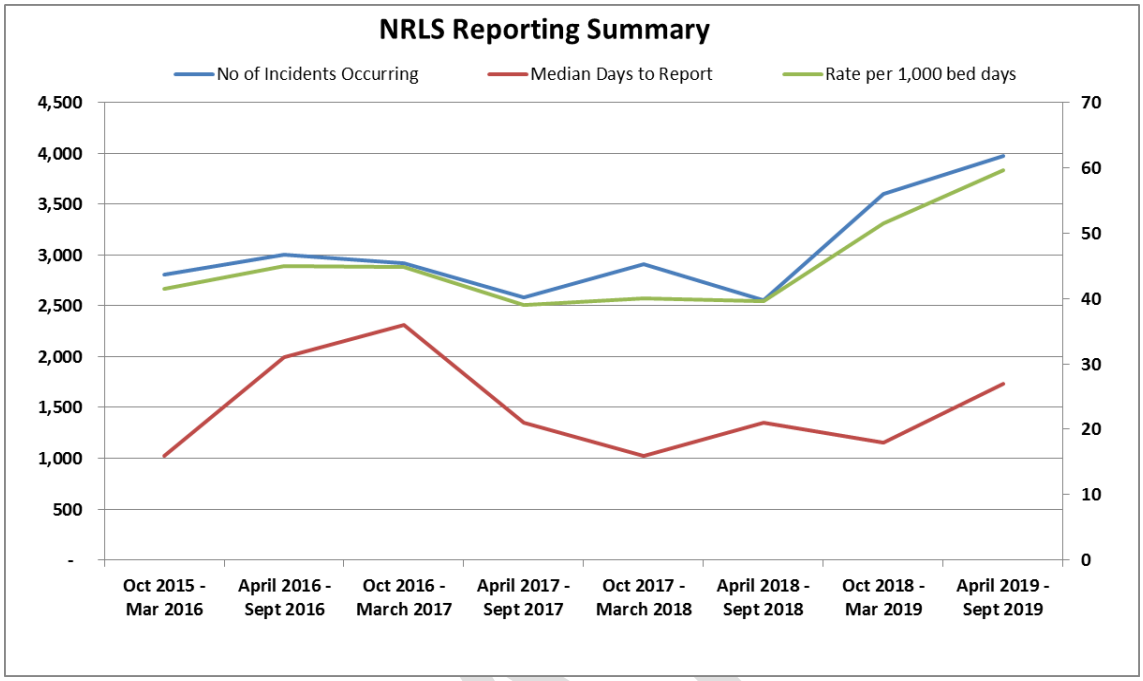
The latest published data for Southport & Ormskirk shows a significant increase in the number of incidents reported in the six months from April 2019 – September 2019, with 3,970 incidents reported (3,598 in the previous 6 month period). The increase can be attributed to;

- An increase in the number of Implementation of care and ongoing monitoring / review incidents, from 378 reported October 2018 – March 2019 to 652 reported April 2019 – September 2019. This is due to the requirement to report all pressure ulcers/deep tissue injuries, including those present on admission to the hospital.
- An increase in the number of incidents reported related to staffing and other incidents relating to the Trust's infrastructure. This also includes bed shortages and boarding patients. These incidents have increased from 246 to 382.
- An increase in the number of consent, communication, confidentiality incidents. This increase can be attributed to the reporting of AKI documentation issues which is now reported on Datix following monthly audits.
- The number of medication incidents has increased from 180 to 210.
- The number of access, admission, transfer, discharge (including missing patient) incidents has increased from 909 to 958 as a result of the 'Lost to Follow-up issue.

This increase in reporting has resulted in an increase in our reporting per '000 bed days and a higher ranking against other Acute trusts (22/130, previously 29/131). There has however been an increase in our median days to report to the NRLS, from 18 to 27 days, this increase has been caused by delays in incident management within the CBU's. The Trust is however lower than the national average of 29 days. The performance is illustrated in the table and graph below.

Time period	No of incidents occurring	Median Days to Report	Rate per 1,000 bed days	Position based rate per 1,000 Bed days- all Acute Trusts
Apr 2019 – Sept 2019	3970	27	59.6	22/130
Oct 2018 – Mar 2019	3598	18	51.44	29/131
April 2018- Sept 2018	2,555	21	39.6	83/131

The Trust considers that this data is as described for the following reasons: we report all relevant incidents through the national central reporting scheme. The figures supplied are provided from the National reporting and Learning System (NRLS) and are only provided currently for the first six months of the reporting year.

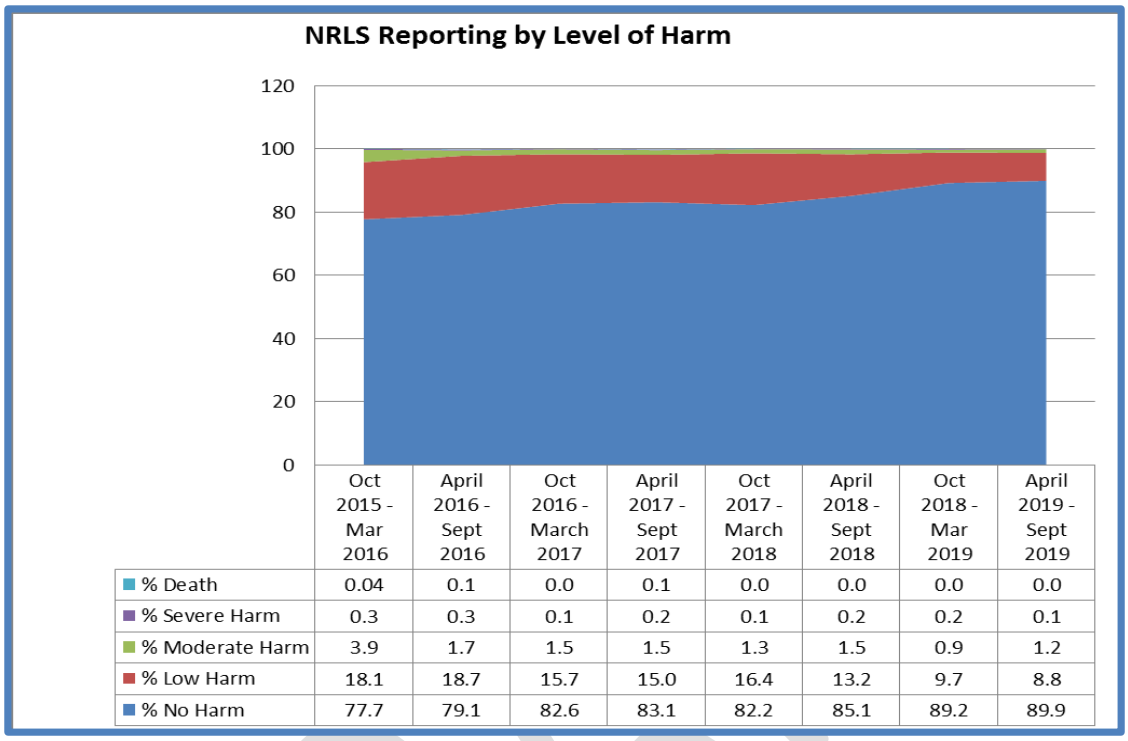


Incident Reporting by Harm

Analysis of the patient safety incidents by level of harm is favourable. 98.7% of all reported incidents caused no or low harm to the patient, 4 severe harms and 1 death were reported. The table below compares data for Southport & Ormskirk with the average for all Acute Trusts and highlights the higher proportion of no harm and low harm incidents compared to the national average and lower incidents of moderate, severe harm or death.

	% No Harm	% Low Harm	% Moderate Harm	% Severe Harm	% Death
ALL ACUTE TRUSTS	75.2	22.7	1.8	0.2	0.1
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	89.9	8.8	1.2	0.1	0.0

The graph below shows the proportion of incidents reported by Southport & Ormskirk over time and demonstrates the shift in the proportion of no harm incidents reported.



	Oct 2015 - Mar 2016	April 2016 - Sept 2016	Oct 2016 - March 2017	April 2017 - Sept 2017	Oct 2017 - March 2018	April 2018 - Sept 2018	Oct 2018 - Mar 2019	April 2019 - Sept 2019
% Death	0.04	0.1	0.0	0.1	0.0	0.0	0.0	0.0
% Severe Harm	0.3	0.3	0.1	0.2	0.1	0.2	0.2	0.1
% Moderate Harm	3.9	1.7	1.5	1.5	1.3	1.5	0.9	1.2
% Low Harm	18.1	18.7	15.7	15.0	16.4	13.2	9.7	8.8
% No Harm	77.7	79.1	82.6	83.1	82.2	85.1	89.2	89.9

Incident Reporting by Category

All incident categories and sub-categories contained within each Trust's local incident management system are mapped to the national Common Classification System (CCS) coding, which enables benchmarking across all reporting organisations. The way local codes are mapped can differentiate between organisations and can account for some of the differences between Trusts.

The table below shows the proportion of incidents reported by CCS code; comparing all Acute Trusts with Southport & Ormskirk.

	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	ALL ACUTE TRUSTS
Access, admission, transfer, discharge (including missing patient)	24.13	12.79
Implementation of care and ongoing monitoring / review	16.42	18.62
Patient accident	11.94	13.60
Treatment, procedure	10.35	11.29
Infrastructure (including staffing, facilities, environment)	9.62	5.29
Documentation (including records, identification)	8.31	6.15
Consent, communication, confidentiality	6.98	4.26
Medication	5.29	10.42
All other categories	3.40	8.27
Clinical assessment (including diagnosis, scans, tests, assessments)	2.37	6.43
Medical device / equipment	1.18	2.87

The table above highlights the following:

- The Trust continues to report a lower proportion of Medication, Clinical assessment, and Medical device incidents, which could indicate under reporting.
- The Trust is reporting a higher proportion of Access, admission, transfer, discharge (including missing patient) incidents than peer organisations. This is primarily due to the reporting of Bed management incidents.
- The Trust is reporting a higher proportion of Documentation (including records, identification) and Consent, communication, confidentiality incidents. This has been impacted by the reporting of AKI documentation issues.

Conclusion

- The latest reporting summary is positive for the Trust. Incident reporting has increased further whilst the level of harm being caused to our patients has decreased further.
- The Trust continues to be in the upper-quartile for incident reporting against other Acute Trusts.
- The Trust recognises there are still elements of under reporting within the Trust and continues to work with the relevant areas to address potential under-reporting.
- Whilst the median days to report incidents to NRLS has increased by nine days, it is still lower than the national average. This will continue to be addressed by supporting the CBU's to manage and close their incidents.

3.13 Pressure Ulcers

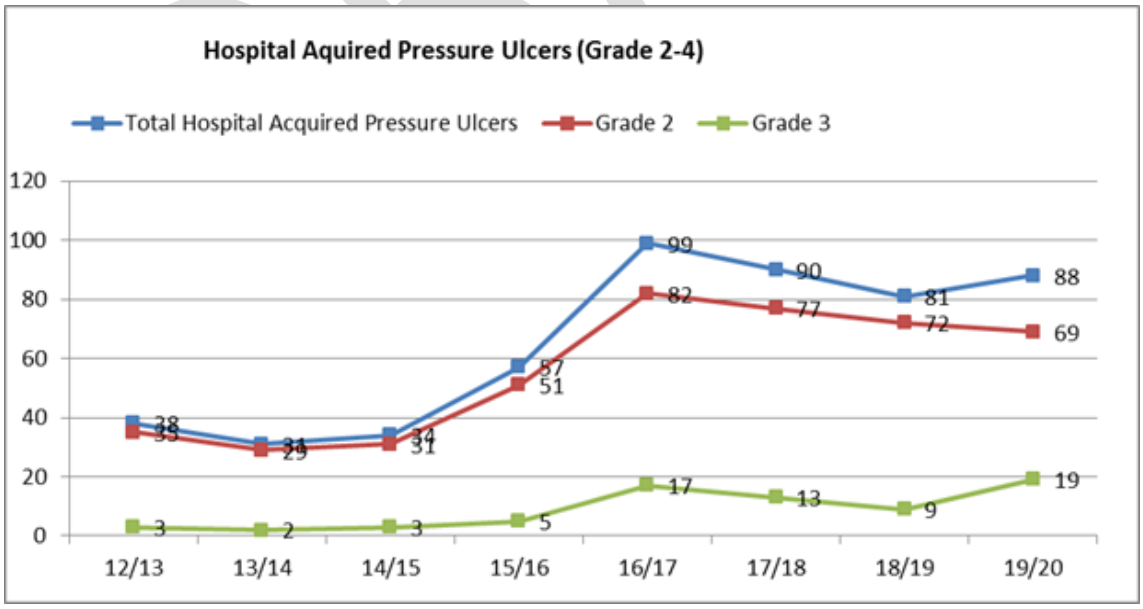
Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four categories, with one being the least severe and four being the most severe. The pressure ulcers reported include all validated avoidable / unavoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.

The pressure ulcer numbers include all pressure ulcers that occurred from 72 hours after admission to this Trust

So we can know if we are improving, even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report pressure ulcers in different ways, and their patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 occupied bed days	0.58

We now include unstageable and deep tissue as category 3 pressure ulcers as of July 19 so this may account towards the increase in category 3 ulcers.



This is a multi-disciplinary team approach to managing pressure ulcers. All teams identify small changes that they can make that will make a difference in pressure ulcer management. The CCGs discuss Trust performance in pressure ulcer management on a monthly basis.

3.14 Falls

There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.

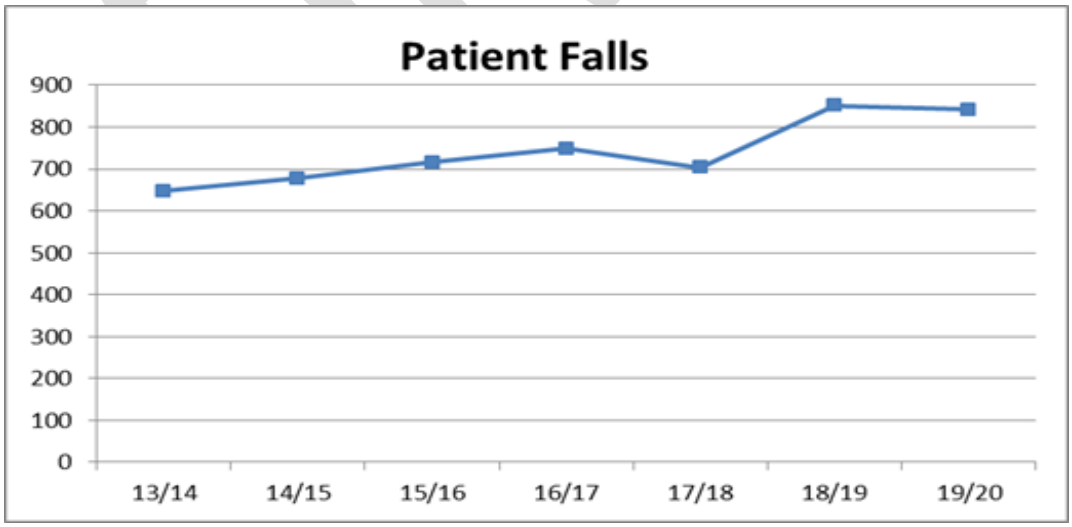
This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause. This includes avoidable and unavoidable falls sustained at any time during the hospital admission.

Apr 18 – March 2020	19	Falls that caused at least moderate' harm

In order to know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us to other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 occupied bed days	5.5

The total number of patient falls has decreased slightly during 2019 / 2020



During 2019 / 20 the Trust launched a new falls strategy and this will continue to be implemented during 2020 / 21 to improve falls care within the Trust.

The focus on falls initially commenced with a review of the risk assessment and care planning process. These key documents were reviewed and new documents were launched which complied with NICE Clinical Guideline 161 in relation to the risk assessment and multifactorial intervention for patients at risk of falls, removing the grading of falls risk and promoting the activation of care plans tailored to suit an individual's needs as soon as they are identified at any risk of falling. Red walking frames were also introduced on the frailty ward to increase visibility and encourage safe mobility. The new documents were launched with education and support to the clinical teams and the compliance with these was noted to improve over the course of the year to achieve the target of 95% compliance as per the quality contract, in quarter 3 (Q4 was not audited due to COVID-19).

2019/2020	Target	Quarter 1	Quarter 2	Quarter 3
All eligible adult in-patients defined by NICE CG 161 (June 2013) to be risk assessed across the whole trust using an appropriate tool.	**95%**	**56%**	**89%**	**97.6%**
Of the eligible in-patients identified as at risk of falling to have a care plan in place across the whole trust	**95%**	**72%**	**87%**	**97.6%**

The ultimate aim alongside improving risk assessment, care plans and implementation of key care actions, is to reduce the number of falls and the harm sustained by patients experiencing a fall during their hospital stay. In March 2020, the Trust invested in equipment including falls alarms and lifting devices to further improve patient safety and ensure evidence-based best practice clinically for people before and after a fall. These items enable to delivery of best clinical practice and support the post-falls assessment tool to ensure safe management of patients who have fallen.

Appendix 1 - The national clinical audits that the Trust participated in during April 2019 – March 2020 are as follows:

Not Eligible – 15

Participated/participating – 59

Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)	All eligible cases submitted
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons (BAUS)	Not applicable
BAUS Urology Audit - Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)	All eligible cases submitted
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons (BAUS)	All eligible cases submitted
BAUS Urology Audit - Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)	All eligible cases submitted
BAUS Urology Audit - Radical Prostatectomy	British Association of Urological Surgeons (BAUS)	All eligible cases submitted
Care of Children in Emergency Departments	Royal College of Emergency Medicine (RCEM)	All eligible cases submitted
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	All eligible cases submitted
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	All eligible cases submitted
Elective Surgery - National PROMs Programme	NHS Digital	All eligible cases submitted
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons (BAETS)	Not applicable
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians (RCP)	All eligible cases submitted
Head and Neck Audit (HANA)	Saving Faces	Not applicable
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD Registry Ltd	All eligible cases submitted
Major Trauma Audit	Trauma Audit Research Network (TARN)	All eligible cases submitted
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Public Health England (PHE)	All eligible cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	All eligible cases submitted
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	All eligible cases submitted
Mental Health - Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)	All eligible cases submitted
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support	National Collaborating Centre for Mental Health (NCCMH)	Not applicable
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH)	Not applicable
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Royal College of Physicians (RCP)	All eligible cases submitted

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National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons (RCS)	Not applicable
National Audit of Cardiac Rehabilitation (NACR)	University of York	All eligible cases submitted
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	All eligible cases submitted
National Audit of Dementia (Care in general hospitals)	Royal College of Psychiatrists (RCPsych)	All eligible cases submitted
National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	Not applicable
National Audit of Pulmonary Hypertension (NAPH)	NHS Digital	Not applicable
National Audit of Seizure Management in Hospitals (NASH3)	University of Liverpool	All eligible cases submitted
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)	All eligible cases submitted
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	Not applicable
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	Not applicable
National Cardiac Audit Programme (NCAP)	Barts Health NHS Trust	We are currently behind with MINAP and heart failure data inputting
National Clinical Audit of Anxiety and Depression	Royal College of Psychiatrists (RCPsych)	Not applicable
National Clinical Audit of Psychosis	Royal College of Psychiatrists (RCPsych)	Not applicable
National Diabetes Audit – Adults	NHS Digital	All eligible cases submitted
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology (BSR)	All eligible cases submitted
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)	All eligible cases submitted
National Gastro-intestinal Cancer Programme	NHS Digital	All eligible cases submitted
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	All eligible cases submitted
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)	All eligible cases submitted
National Maternity and Perinatal Audit (NMPA)	Royal College of Paediatrics and Child Health (RCPCH)	All eligible cases submitted
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)	All eligible cases submitted
National Ophthalmology Audit (NOD)	Royal College of Ophthalmologists (RCOphth)	All eligible cases submitted
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)	All eligible cases submitted
National Prostate Cancer Audit	Royal College of Surgeons (RCS)	All eligible cases submitted
National Smoking Cessation Audit	British Thoracic Society (BTS)	All eligible cases submitted
National Vascular Registry	Royal College of Surgeons (RCS)	Not applicable
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Not applicable
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	Not applicable
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	All eligible cases submitted
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists (RCPsych)	Not applicable
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England (PHE)	All eligible cases submitted
Sentinel Stroke National Audit programme (SSNAP)	King's College London	All eligible cases submitted

DRAFT

Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	All eligible cases submitted
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine (SAM)	All eligible cases submitted
Surgical Site Infection Surveillance Service	Public Health England (PHE)	All eligible cases submitted
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	All eligible cases submitted
UK Parkinson's Audit	Parkinson's UK	Not all eligible cases as lead consultant went on long term sick leave

The national confidential enquiries that Southport & Ormskirk Hospital NHS Trust participated in during April 2019 – March 2020 are as follows:

	Number of clinical questionnaires returned	Number of case notes returned
Long term ventilation	1 / 1	All requested
Bowel Obstruction	3 / 7	All requested
Out of hospital cardiac arrest	1 / 1	All requested
Dysphagia in people with PD	0 / 4	All requested

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PART 4

ANNEX

STATEMENTS OF ASSURANCE

The Draft Quality Account was circulated for comments to both CCGs, both Healthwatches and to the Overview and Scrutiny Committee. On the following pages are the responses received.

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4.1 Sefton Healthwatch

healthwatch Sefton

Southport & Ormskirk Hospital NHS Trust.
Quality Account 2019-20 Commentary.

Healthwatch Sefton would like to thank the Trust for sharing the draft Quality Account with us and for asking us to comment on the report. From attending the local 'Quality Accounts' session on the 9th October, we were able to listen to a presentation from the Trust. The presentation slides together with the quality account report made the information easier to understand.

Southport & Ormskirk Hospital Trust during this period have been and continue to be very supportive and welcoming to Healthwatch Sefton. Patient engagement stands have been facilitated across both sites and Listening events held across the Trust by Healthwatch Sefton have been valued. Healthwatch Sefton's comments and viewpoints have been acknowledged and listened to with a view to improving services and showing transparency within the Trust. During this period, we also supported the Trust to engage with their patients on 'discharge from hospital' as part of an Always Event.

The presentation in particular was user friendly and provided clear and concise information. The presentation gave clear numbers relating to different departments of the Trust such as admissions from the accident and emergency department, patients treated within 18 weeks of referral, the number of staff employed, the number of births and also showcased a number of the key highlights for 2019-20.

However in reading the report, we were concerned with the number of abbreviations used. The report was however easier to read than previous years. In reading the report, it felt more positive, honest and responsive. We felt it was a compassionate report which focussed on patients and families.

On Page 9, it mention 'tier 1, 2' in relation to training. Could this be explained in light of confusion with COVID-19 tiers as this was confusing?

The Trust showed good practice of sharing their work with the community by holding an open day event at Ormskirk hospital for the local community. This patient engagement theme was continued with the holding of celebrating Quality Street, an event to focus on quality work within the Trust.

We were also pleased to see to the launch of Pets as Therapy within the Trust. This demonstrates the Trusts openness to innovative ideas to help improve the quality and care of patients.

Healthwatch Sefton
Sefton CVS, 3rd Floor, Suite 3B, North Wing, Burlington House,
Crosby Road North, Waterloo, L22 0LG
Tel: 0800 206 1304/ 0151 920 0726 ext 240 Mobile: 07434810438
info@healthwatchsefton.co.uk, www.healthwatchsefton.co.uk
Healthwatch Sefton *Company Ltd by Guarantee Reg. No: 8453782*

It was good to read about the development of the falls strategy and investments to decrease the number of hospital falls and improve the care of patients who suffer a fall. We would also like to note the new Dementia & delirium team led by the newly recruited Admiral Nurse. This work to provide improvements for individualised plans, advice and guidance, signposting for patients and their family to extend support networks post discharge and hopefully help to prevent the number of readmissions patients is welcomed. There are also good examples of collaborative work between the frailty team and continence assessments. The Trust appears to have a strong Older Peoples Care Programme in place.

The Home First pathways service gives patients the chance to be discharged home before assessment takes place to determine ongoing care needs but needs to be completed with careful consideration and consistency with each individual patient to ensure some patients are not discharged without the appropriate and necessary support & care services in place. We were also pleased with the 24/7 critical care outreach team to help identify and care for the deteriorating patients effectively.

We noticed the number of departments requiring improvement following the last Care Quality Commission (CQC) report that was published in November 2019 and as a Healthwatch we would appreciate being updated on progress regarding these improvements. We were pleased with the recommendation by CQC to have communication aids/ tools in place for patients with additional needs and that a purple folder in now available on each ward to support staff with this.

The transform work with local schools and the work with the girl guides who have been hand making comfort packs that are given to relatives who stay overnight in hospital unprepared was a really good idea and again shows engagement with the voluntary, community and faith sector. We were also impressed with 'Queens Court' volunteers who are now trained to provide support to families of dying patients. We would however like the Trust to ensure volunteers are not subsequently over burdened and are properly supported with their volunteer roles.

The report highlighted that the seven day hospital service programme is being monitored, progressed and improved upon with recommendations on must do/ should do and areas of improvement. Healthwatch Sefton again would like to be kept updated on improvements and progress in this area.

There is a concern regarding ambulance handovers to the Accident & Emergency department and acknowledge the impact this may have. Another concern we picked up from the report is the increase in hospital acquired pressure ulcers.

The report acknowledged the impact of the COVID-19 pandemic and huge palliative care response placed on the Trust. There is recognition that the pandemic will affect all areas of the Trusts business. Healthwatch Sefton would again like to be kept

updated and kept informed of any subsequent changes to services. The report highlighted areas currently put on hold due to Covid such as planned focus groups with the local population to identify priorities for 2020-2021.

We were pleased with the ongoing progress of the 'patient experience' group, which Healthwatch Sefton has a seat on and the development of a new patient experience strategy. We noted also that complaints and compliments are acknowledged and valued by the Trust in order to review services and make improvements. The recent improvements in complaints response times are welcomed and the increase shows that the trust is viewed as being more open and approachable. The introduction of the Patient Advice and Liaison service is great to see.

We were also impressed with the Trusts culture of promoting openness and transparency to improve service user's safety and the quality of healthcare systems. The 'Freedom to Speak Up' offer for staff if they have concerns over quality of care, patient safety, bullying or harassment within the Trust which highlights best practice is great to see. In terms of looking at the issue of staff, it is good to see the vacancy rates reducing.

We have over this period undertaken a specific piece of engagement work in the Ophthalmology department and have shared this feedback with the Trust.

We have also raised a number of equality issues with the trust which are currently being addressed included vegan options at meal times, the height of appointment desks and support for patients who have visual impairments when visiting one of the trusts sites.

Healthwatch Sefton will continue to work in partnership with the Trust to support the on-going work to improve the overall care and services provided to both patients, their visitors and staff. We would like to thank staff working across all trust sites for the care they have provided to the local population to keep us safe during this pandemic.

4.2 West Lancashire CCG and Southport & Formby CCG

NHS South Sefton Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

Quality Account Statement – Southport & Ormskirk Hospitals NHS Trust.

South Sefton CCGs hosted a Quality Accounts Day on Friday 9th October 2020. Providers were invited to present their accounts and stakeholders were asked to provide feedback. Stakeholders included:

- South Sefton and Southport and Formby CCGs
- Liverpool CCG
- Knowsley CCG
- Healthwatch Sefton, Liverpool and Knowsley
- Health Education England
- NHS England/Improvement
- Sefton MBC
- NHSE Specialised Commissioning
- CQC

The Stakeholders appreciate the Trust's focus on quality and safety at a time of a global pandemic. They recognise this has required different ways or working during the COVID 19 period and is reflected in the accounts.

The stakeholders welcomed the opportunity to jointly comment on Southport & Ormskirk Hospitals NHS Trust's Quality Account for 2019/20. The CCGs have worked closely with the Trust throughout 2019-20 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

It is noted that the Quality Account that is being reviewed is a draft version and the stakeholders look forward to receiving the finalised account. The work the Trust has undertaken and described within this Quality Account continues to promote patient safety and the quality of patient experience and endorses the Trust's commitment to promote safety and quality of care.

The Commissioners acknowledge the Quality Account for 2019/20 and the continued focus of work on the four elements to continuous improvement:

- Care for the older patient
- Medicines management
- Care of the deteriorating patients
- Infection prevention and control.

The stakeholders note the key priority for the Trust for 2019/20 relate to workforce issues; with a quality focus on patient experience and reducing patient harm. It was noted that the Trust has put a number of measures in place to source staff from various sectors and have strengthened university ties.

The group noted the quality highlights for 2019/20. It was assuring to note the improvements in mortality numbers and that work in critical care has been effective. The Trust have acknowledged there is more work to do in this area but feel great improvements have been made across the system.

The stakeholders noted it was positive to see the improvement work around complaints. However, the quality account presented provided limited information about patient experience. This could be strengthened in the final version.

The Trust has made it clear that complaints management is of the highest importance and the quality of Trust responses is important as it can demonstrate that the Trust has really listened. Patient experience is really important and is embedded within the new strategy which has recently gone to the Trust board.

The CQC gave the Trust a "requires improvement" rating in November 2019. It was assuring to note that the work quality plan utilised CQC evidence provided to the Trust in order to increase efficiency in relation to AED improvements.

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and the ambitions moving forward. We understand the Trust's Quality Strategy has a number of individual workstreams that will take into account patient feedback on progress made.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account against the latest nationally published data where possible.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers positive outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

We acknowledge the actions the Trust is taking to improve the quality as detailed in this Quality Account. It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

South Sefton and Southport & Formby CCGs
Signed

Fiona Taylor, Chief Officer — Date: 16th November 2020

Liverpool CCG

Signed

Jane Lunt, Chief Nurse — Date: 19th November 2020

Knowsley CCG

Signed

Dianne Johnson, Chief Executive — Date: 10th November 2020

GLOSSARY	
A&E (AED)	Accident and Emergency Department
ACS	Appropriate Care Score - All measures passed for an individual patient
AQ	Advancing Quality
CBU	Clinical Business Unit
CCU	Coronary Care Unit
C.diff	Clostridium difficile
CQC	Care Quality Commission
CQS / CPS	Composite quality Score - Aggregated delivery of several clinical processes
CQUIN	Commissioning for Quality and Innovation
DAHNO	Data for Head and Neck Oncology
DoLs	Deprivation of Liberty
DON	Director of Nursing
DDON	Deputy Director of Nursing
DIPC	Director of Infection Prevention and Control
DNACPR	Do Not Attempt to Resuscitate
DSSA	Delivering Same Sex Accommodation
EoL	End of Life
EPaCCS	Electronic Palliative Co-ordination System
FLO-ELA	FLuid Optimisation in Emergency LAparotomy Trial
GSFAH	Gold Standard Framework Acute Hospitals
HAPS	Hospital Acquired Pressure Sores
HCAI	Health Care Acquired Infections
HCC	Health Care Commission
HES	Hospital Episode Statistics
HONS	Heads of Nursing
HRG	Healthcare Related Groups
HSMR	Hospital Standardised Mortality Ratio
HQIP	Healthcare Quality Improvement Partnership
IBD	Irritable Bowel Disease
ICT	Integrated Care Teams
IV	Intravenous
LD	Learning Difficulties
LeDeR	The Learning Disabilities Mortality Review
MDT	Multi-Disciplinary Team
MINAP	Myocardial Infarction National Audit Project

DRAFT

MRSA	Methicillin Resistant StaphlococcusAureus
MSA	Mixed Sex Accommodation
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide
NICE	National Institute of Clinical Excellence
NICOR	National Institute for Clinical Outcome Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
OSA	Obstructive Sleep Apnoea
OSC	Overview and Scrutiny Committee
PDR	Personal Development Review
PLACE	Patient Lead Assessments of the Care Environment
PREMIER	American Advancing Quality lead company
PPC	Preferred Place of Care
PROMS	Patient Reported Outcome Measures
RAG	Red, Amber, Green
RAM	Risk Adjusted Mortality
RCOG	Royal College of Obstetricians and Gynaecologists
RCPH	Royal College of Paediatric and Child Health
REoLT	Rapid End of Life Transfer
Red Bag	When a care home resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items.
SHMI	Standardised Hospital Mortality Indicator
SIRRS	Serious Illness Recognition and Response Committee
STEIS	Strategic Executive Information System
SUI	Serious Untoward Incident
SUS	Secondary Users Services
TARN	Trauma Audit and Research Network
UTI	Urinary Tract Infection
VAP	Ventilator Acquired Pneumonia
VitalPAC	is a mobile software information system for monitoring the vital signs of hospital patients
VTE	Venous Thrombo-Embolism
WRVS	Women's Royal Voluntary Service

DRAFT

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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 December 2020**
Agenda Item	**TB197/20**	**FOI Exempt**	**NO**
Report Title	**MATERNITY SERVICES**		
Executive Lead	Bridget Lees Director of Nursing/Midwifery		
Lead Officer	Lynne Eastham, Head of Midwifery/Nursing		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report is the second report intended to provide the Trust Board with an overview and update on Maternity Services in line with the Trust Board Annual Cycle of Business providing an update on:

- Progress of 'Better Births' (2016) regarding delivery of Continuity of Carer and the current position in line with the regional and national ambition
- Progress to achieving 'Saving Babies Lives' in line with the Safer Maternity care agenda (2017)
- Perinatal Mortality Rate
- Update on the CNST Maternity Incentive Scheme - Year 3 (2020)
- Workforce – Maternity staffing Review (Period April 2020 to September 2020)
- Update on the Care Quality Commission

Executive Summary

Continuity of Carer

This trajectory was set pre Covid-19 and in August 2020, was reviewed under the 'Implementing Phase 3 of the NHS response to the Covid-19 pandemic' (NHS) with an expectation now of 35% of women being on the pathway by March 2021. Due to the size of the maternity service and the midwifery workforce we are not able to implement this model in a phased approach. Support from Claire Mathews, North West Regional Midwife, NHS England, with a check and challenge' event with the Maternity team took place in August 2020.

The feedback received at the Check and Challenge meeting will inform our business planning and vision for the development of the new maternity model. At this current time we have been unable to progress any organisational change due to Covid-19 guidance.

Saving Babies Lives

Improvement plan in place which has made good progress and is nearing completion of the five elements:

- Reducing Smoking in Pregnancy
- Risk Assessment and Surveillance of Foetal Growth Restriction:
- Raising Awareness of Reduced foetal movements
- Effective monitoring in labour
- Preventing preterm birth

However, there are still some issues which are yet unresolved with the Maternity Information System (System C) which include:

- MSDS data submission – This is because the Trust Information system does not conform to all of the MSDS submission requirements and are waiting for an upgrade from System C who provide the Maternity Information System. This upgrade is expected to take place on the 19th November 2020
- GROW Interface - foetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity. Growth of the foetus is measured and monitored by manual plotting of measurements during antenatal assessments. However, there are risks of errors associated

with manual plotting. GROW is an electronic tool which interfaces with the Maternity Information System to assess foetal growth by using customised growth charts bespoke for each woman. There has been a delay in implementing GROW due to System C upgrading the current Maternity Information System. The upgrade took place on the 2th November 2020 and is currently being tested

Perinatal Deaths Mortality
From February 2020, there has been a noted increase in stillbirths, but no themes. There has also been in increase in neonatal admissions where intrapartum management affected their outcome.

Themes have been identified which include:

- Failure to escalate
- CTG interpretation
- Roles & responsibilities
- Ward rounds have been identified

A plan is in place to have focused leadership on the Delivery Suite along with an improvement plan overseen by the Head of Midwifery and Clinical Director

Due to the impact of Covid-19 the scheme was temporarily put on hold and was relaunched on the 01 October 2020 with a deadline for submission of achieving the 10 safety actions by the 20 May 2021. The re launch has come with some changes to the actions and altered timescales and the action plan implemented by the CBU is now being amended to reflect these, following which updates on progress and any risks to compliance will be provided to Trust Board. CNST Maternity Incentive Scheme - Year 3 (2020)

Workforce
The impact of Covid-19 has been a challenge on staffing with sickness absence rates increasing to 14-15%. These pressures have been managed by temporarily reconfiguring the inpatient areas to condense activity and increased oversight by the senior midwifery team to support safe staffing levels. The unit has not needed to close.

The percentage of one to one care in labour remains a priority with the aim to achieve 100%. During the reporting period there has been one occasion when one to one care could not be provided.

In the first wave of Covid-19 the home birth service had to be temporarily suspended. This was due to staff sickness and concerns regarding NWAS support in an emergency through the pandemic. However, the home birth service has continued throughout this wave with the home birth rate continuing to be above target at 2.23% (YTD).

CQC
Maternity Services was not assessed in 2019 however share oversight of the CQC Improvement Plan for Paediatrics and Sexual Health. The focus for Maternity and Specialist Services CBU is in the 'Well Led' domain.

Recommendation	
The Board is asked to note the progress to date with the Maternity agenda.	
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:**
Lynne Eastham, Head of Midwifery	Catherine Boyle and Mrs Uma Karthikeyan

Southport and Ormskirk Hospital NHS Trust

Trust Board Report – Maternity Services

Introduction

This report is the second report intended to provide the Trust Board with an overview and update on Maternity Services in line with the Trust Board Annual Cycle of Business.

This report will give an update on:

- Progress of 'Better Births' (2016) regarding delivery of Continuity of Carer and the current position in line with the regional and national ambition
- Progress to achieving 'Saving Babies Lives' in line with the Safer Maternity care agenda (2017)
- Perinatal Mortality Rate
- Update on the CNST Maternity Incentive Scheme - Year 3 (2020)
- Update on the Care Quality Commission
- Workforce – Maternity staffing Review (Period April 2020 to September 2020)

Continuity of Carer

In 2016, the 'Better Births: A 5 Year Forward View' report (NHS England 2016) was published describing the vision for Maternity Services in England. Set out in this report is the recommendation that all women, babies and families should have 'continuity of carer' by a named midwife or small team who will look after them during their entire maternity journey.
Continuity of Carer is being implemented across England through the Maternity Transformation Programme working through Local Maternity Systems (LMS) with an expectation that 50% of women will be on the pathway. This trajectory was set pre Covid-19 and in August 2020, was reviewed under the 'Implementing phase 3 of the NHS response to the Covid-19 pandemic' (NHS) with an expectation now of 35% of women being on the pathway by March 2021.

Delivery Date	Percentage of women on Pathway
March 2019	21%
March 2020	30%
March 2021	35% booked on the pathway before 29th week with equal or more than this amount for Black and Asian women and those from most deprived neighbourhoods
March 2022	Continue at 2021 percentage But with most (more than 50%) in receipt of continuity of carer including women from for black, Asian and multiple deprivation, cared for antenatally, postnatally and in labour
Onwards	In line with the NHS Long Term Plan 75% of women from the above groups.

Lynne Eastham, Head of Midwifery/Nursing
November 2020

In 2019, the Sapphire Team was implemented to provide Continuity of Carer for those women choosing to have their babies at S&O but who live outside the area, with 14% of women on the Continuity of Care pathway

Due to the size of the maternity service and the midwifery workforce we are not able to implement this model in a phased approach.
Over the last 18 months we have engaged with the Midwifery and Consultant Obstetric team and staff side representatives via focus groups to determine the feasibility of the different models to implement 'continuity of carer' and have developed a bespoke workforce model.
To test out our model we have also previously engaged with the Local Maternity System (LMS). Earlier in the year, a Statement of Case was submitted to support funding to implement the preferred option of a combination of case loading and team midwifery, however this was not successful due to the cost to implement the model and further assurance was requested by the Executive Team.
External support from Claire Mathews, North West Regional Midwife, NHS England, took place in August 2020 which included a 'check and challenge' event with the Maternity team.
The feedback received at the Check and Challenge meeting will inform our business planning and vision for the development of the new maternity model. At this current time we have been unable to progress any organisational change due to Covid-19 guidance.

Saving Babies' Lives
Saving Babies Lives Care Bundle (version 2) has been produced to build on the recommendations from version one and to further address perinatal mortality. This bundle includes 5 elements which focus on the recognition and detection of risks associated with perinatal mortality and morbidity, reporting and referral processes, training of staff and auditing of practice and outcomes. The five elements being:

- Reducing Smoking in Pregnancy
- Risk Assessment and Surveillance of Fetal Growth Restriction:
- Raising Awareness of Reduced Fetal movements
- Effective monitoring in labour
- Preventing pre term birth

An improvement plan is in place (appendix 2)

Table Overview of progress

Description of element	**RAG**
Reducing smoking in pregnancy by assessing exposure to carbon monoxide (CO) as appropriate to assist in identifying smokers (or those exposed to CO through other sources) and refer them for support from a trained stop smoking advisor.	
Interventions	Blue
Continuous learning	Blue
Process Indicators	Amber
Outcome Indicators	Green
Risk assessment and surveillance of pregnancies for fetal growth restriction (FGR)	
Prevention	Blue
Risk assessment	Blue
Management	Amber
Continuous Learning	Green
Process Indicators	Amber
Raising awareness of reduced fetal movement	
Intervention	Green
Process	Green
Outcome	Blue
Effective fetal monitoring during labour	

Lynne Eastham, Head of Midwifery/Nursing
November 2020

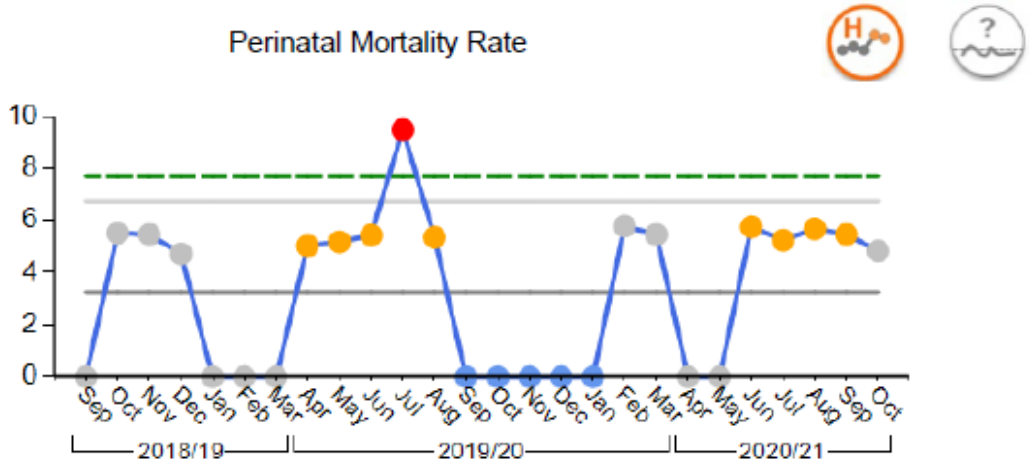
Intervention	Green
Process	Green
Outcome	Blue
Reducing preterm birth	
Intervention	Green
Process	Blue
Outcome	Blue

Good progress has been made in working towards compliance with all elements however there are still some ongoing issues which include:

- **MSDS data submission** – This is because the Trust Information system does not conform to all of the MSDS submission requirements and are waiting for an upgrade from System C who provide the Maternity Information System. This upgrade is expected to take place on the 19th November 2020
- **GROW Interface** - Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity. Growth of the fetus is measured and monitored by manual plotting of measurements during antenatal assessments. However, there are risks of errors associated with manual plotting. GROW is an electronic tool which interfaces with the Maternity Information System to assess fetal growth by using customised growth charts bespoke for each woman.
  There has been a delay in implementing GROW due to System C upgrading the current Maternity Information System. The upgrade took place on the 2th November 2020 and is currently being tested
- **Completion of audits** – There has been delays in completion of audits to demonstrate compliance to guidelines as a result of competing priorities which have been Covid-19 related. These are now being actioned.

We continue to report quarterly progress NHS England, Cheshire & Mersey Clinical Partnership, and the regional Safety Improvement Group

Perinatal Mortality
Perinatal mortality includes stillbirths and neonatal deaths in the first week of life. All stillbirths and deaths are reviewed at the weekly patient safety meetings and reported to SIRG via a 72 hour review report.



All unexpected admissions of term babies to the neonatal unit are also reviewed and where there are any concerns are also discussed at the CBU patient safety meetings

Lynne Eastham, Head of Midwifery/Nursing
November 2020

From February 2020, there has been a noted increase in stillbirths, but no particular themes have been identified. There have been no cases of stillbirths reported to HSIB.

Feb 2020	March 2020	June 2020	July 2020	Aug 2020	Sept 2020	**Total**
1	1	1	1	1	1	**6**

There has also been in increase in neonatal admissions where intrapartum management affected their outcome.
Themes have been identified which include:

- failure to escalate
- CTG interpretation
- Roles & responsibilities
- Ward rounds

These concerns have been raised by the CBU at SIRG. A plan is in place to have focused leadership on the Delivery Suite along with an improvement plan overseen by the Head of Midwifery and Clinical Director and to report back to SIRG in December 2020.

CNST Maternity Incentive Scheme - Year 3 (2020)

The maternity incentive scheme was launched in 2017/2018 and is now in its third year.
This scheme supports the Safer Maternity Care Ambition by supporting the delivery of safer maternity care by rewarding Trusts that meet ten safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services.
Due to the impact of Covid-19 the scheme was temporarily put on hold and was relaunched on the 1st October 2020 with a deadline for submission of achieving the 10 safety actions by the 20th May 2021.
The re launch has come with some changes to the actions and altered timescales and the action plan implemented by the CBU is now being amended to reflect these, following which updates on progress and any risks to compliance will be provided to Trust Board.

Role of Trust Board
Maternity Services will be expected to provide a report to Trust Board demonstrating achievements of each safety action including evidence. The Trust Board then are required to consider the evidence and complete a declaration form to submit to NHS resolution by the deadline of 20th May 2021.

Workforce
In accordance with requirements for NICE standards for Maternity staffing 'Safe Midwife Staffing in Maternity Settings' (2015), and Clinical Negligence Scheme for Trusts, a bi annual report is submitted to the Board to provide assurance that the midwifery establishments are safe and that staff are able to provide appropriate levels of care to women and babies. The last bi-annual report was presented in May 2020 for period July 2019 – April 2020 inclusive (attached as Appendix 1) with the next report being presented in December 2020.

Four new Consultant Obstetricians commenced in post in June 2020, meetings have been had with the Clinical Director and lead roles have been identified which have been included in job plans

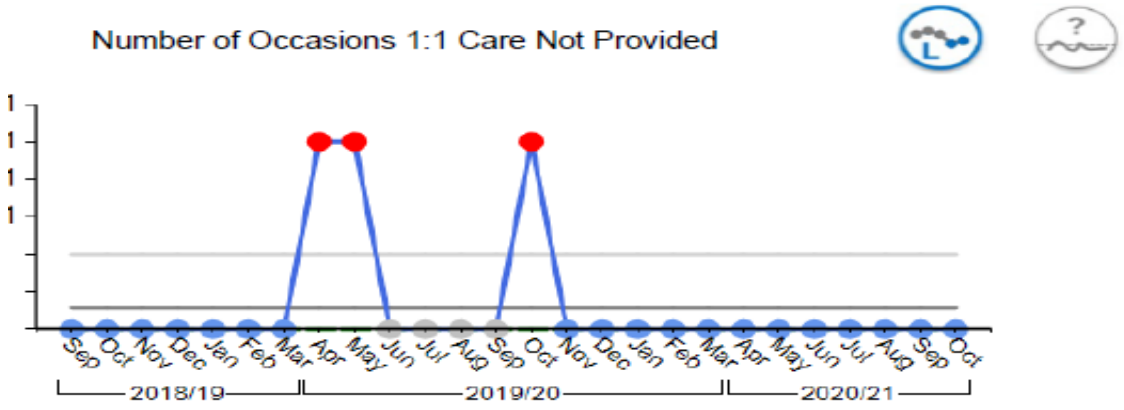
Impact of Covid-19
The impact of Covid-19 has been a challenge due to staff infections, self-isolating and child care issues related to children not being able to attend school. In response to Covid-19 staff

Lynne Eastham, Head of Midwifery/Nursing
November 2020

in the 'at risk' groups have been supported either by working in non-patient facing environments, working from home or being shielded.
Whilst Sickness absence rates increased to 14-15%, this has been managed well. To ensure safety the clinical areas were temporarily reconfigured to reduce capacity and condense activity with the support of staff working flexibly or supporting with NHSP. This has put pressure on the service especially at times of high activity with possible maternity closure only mitigated by utilising the maternity escalation policy and flexibility of staff. The recent incentive scheme has been well received and has now enabled the clinical areas to return to normal.
Senior Midwifery oversight until 8pm and at weekends has been introduced to support staff by having an 'helicopter view'. This enables efficient response to any staffing shortfalls, unpredicted demands on the service and any other concerns that may arise.
Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting

Additional 3pm daily staffing huddles have also been implemented with the senior midwifery team to monitor and support.
Regionally through the Cheshire & Mersey Clinical Partnerships, staffing pressures are on the bi-weekly agenda so that mutual aid can be considered if individual maternity units are in a vulnerable position. Sickness absence rates are now starting to demonstrate improvements.

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



Home Births
In the first wave of Covid-19 the home birth service had to be temporarily suspended. This was due to staff sickness and concerns regarding NWAS support in an emergency through the pandemic. However, despite staffing pressures, the home birth service has continued throughout this wave with the home birth rate continuing to be above target at 2.23% (YTD)

Care Quality Commission
Lynne Eastham, Head of Midwifery/Nursing
November 2020

Our current ratings are:

Safe	Effective	Caring	Responsive	Well Led	Overall
Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Maternity Services was not assessed in 2019, however share oversight of the CQC Improvement plan for Paediatrics and Sexual Health. The focus for Maternity and Specialist Services CBU is in the 'Well Led' domain. The CBU have recruited a Coordinator for Patient Experience and Clinical Standards who commenced in post in November 2020 and will be supporting work going forward

What Next

Key priorities over the next 6 months:

- Complete review of unexpected neonatal admissions to the neonatal unit and embed lessons learnt
- Work toward completing the 10 CNST safety actions
- Implementation of continuity of carer model
- Establish patient experience strategy and the staff recognition approach for the CBU

Lynne Eastham, Head of Midwifery/Nursing
November 2020

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NHS Trust

Maternity Services
Trust Board Report

Presented by Catherine Boyle, Consultant Midwife
and
Mrs Uma Karthikeyan, Clinical Director

NHS
Southport and Ormskirk Hospital
NHS Trust

- Progress of ‘Better Births’ (2016) regarding delivery of Continuity of Carer
- Progress to achieving ‘Saving Babies Lives’ in line with the Safer Maternity care agenda (2017)
- Perinatal Mortality Rate
- CNST Maternity Incentive Scheme
- Workforce
- Update on the Care Quality Commission

Southport and Ormskirk Hospital
NHS Trust

Progress of 'Better Births' (2016) regarding delivery of Continuity of Carer

Delivery Date	Percentage of women on Pathway
March 2019	21%
March 2020	30%
March 2021	35% booked on the pathway before 29th week with equal or more than this amount for Black and Asian women and those from most deprived neighbourhoods
March 2022	Continue at 2021 percentage But with most (more than 50%) in receipt of continuity of carer including women from for black, Asian and multiple deprivation, cared for antenatally, postnatally and in labour
Onwards	In line with the NHS Long Term Plan 75% of women from the above groups.

- Current position 14%

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NHS Trust

Progress to achieving ‘Saving Babies Lives’ in line with the Safer Maternity care agenda (2017)

- Reducing Smoking in Pregnancy
- Risk Assessment and Surveillance of Fetal Growth Restriction
- Raising Awareness of Reduced Fetal movements
- Effective monitoring in labour
- Preventing pre term birth

NHS
Southport and Ormskirk Hospital
NHS Trust

Key challenges to meet Saving Babies Lives

- MSDS data submission
- GROW interface
- Completion of audits

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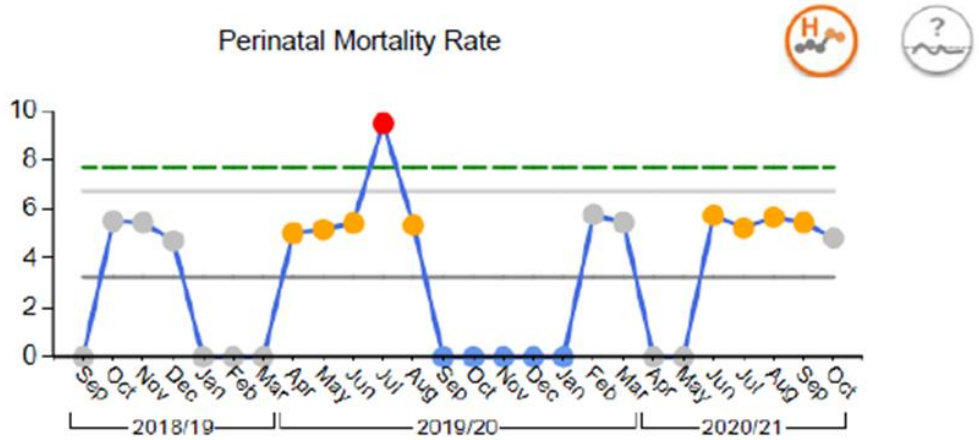
NHS Trust

Perinatal Mortality Rate



Feb 2020	March 2020	June 2020	July 2020	Aug 2020	Sept 2020	Total
1	1	1	1	1	1	6

Southport and Ormskirk Hospital
NHS Trust

Perinatal mortality rate

- Noted increase in stillbirths but no themes identified
- No stillbirths reportable to HSIB (none to date)

- Increase in term admissions to the Neonatal Unit
  - Focussed plan in place to address issues identified

Southport and Ormskirk Hospital
NHS Trust

CNST Maternity Incentive Scheme –Year 3 (2020)

- Relaunch of Maternity scheme in October 2020
- Action plan developed by the CBU being reviewed and amended
- Trust Board are required to review evidence and to complete the declaration form for submission to NHS resolution by May 2021

Southport and Ormskirk Hospital
NHS Trust

Workforce

- Maternity staffing reviewed in line with NICE standards (2015) and CNST
  - Current Midwife to birth ratio is 1:24.28
- Consultant Obstetricians – 4 new Consultants in post, lead roles identified and included in job plans
- Impact of Covid-19 – including patient experience
- Senior Midwifery oversight to support operational delivery and staffing
- Monitoring through the Cheshire and Merseyside Clinical Partnerships

Southport and Ormskirk Hospital
NHS Trust

Care Quality Commission

- Maternity Services was not assessed in 2019 however share oversight of the CQC Improvement plan for Paediatrics and Sexual Health

- The focus for Maternity and Specialist Services CBU is in the ‘Well Led’ domain

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NHS Trust

Key priorities

- Complete review of unexpected neonatal admissions
- Work towards completing the 10 CNST safety actions
- Implementation of continuity of carer model
- Establish patient experience strategy and staff recognition approach for the CBU

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 December 2020**
Agenda Item	**TB198/20a**	**FOI Exempt**	**NO**
Report Title	**LEARNING FROM DEATHS QUARTERLY REPORT - QUARTER 1 AND 2**		
Executive Lead	Dr Terry Hankin, Medical Director		
Lead Officer	Dr Chris Goddard, Associate Medical Director of Patient Safety		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Trust's mortality and learning from deaths.

Executive Summary

The report provides assurance on Learning from Deaths and activity undertaken to reduce avoidable deaths. It reports on national mortality ratios and local Hospital Summary Mortality Rates by condition. The report details the trajectory of mortality ratios and attributes contributing factors. It provides assurance on the implementation of the Structured Judgement Review across the Trust and the outcome of its findings.

The report also provides an update on the following:

1. Mortality Indicators
   - Summary Hospital-level Mortality Indicator (SHMI): 12 month rolling published up to May 2020
   - Hospital Standardised Mortality Ratio (HSMR): Rolling 12 month and in month for June 2020
   - Disease-Specific Mortality Ratios are reported for June 2020

2. Mortality Improvement Activity
   - The Care of the Deteriorating Patient Project is now reported separately to mortality

3. Learning from Deaths: Structured Judgement Reviews (SJRs)
   - Screening rates, first and second stage SJRs and thematic reviews from SJRs are summarised.

4. Next Steps
   Major categories of mortality improvement work are summarised with forecast completion dates.

Recommendations

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

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:**
Dr Chris Goddard	Dr Terry Hankin

NHS
Southport and Ormskirk Hospital
NHS Trust

1. Executive Summary

1.1 HSMR remains in a satisfactory position. SHMI has not made this report but has risen above 100 in the last month. This is due to the rise in respiratory death over the winter period of 2019. Whole system flow was a significant challenge during this period. The effect of COVID -19 on standardised metrics is yet to be seen.

1.2 The SMR for AKI shows significant variation. There are 14 deaths in 12 months with AKI as the coded first consultant episodes (used to calculate HSMR).

1.3 SJR trend over time analysis shows an improvement in the reviewers' opinion of quality of care in the first 24 hours. This likely reflects the investment in urgent care. Care at the end of life shows a deteriorating position. Thus, the overall view of quality is largely unchanged.

1.4 No new avoidable deaths have been highlighted thus far, all deaths with concerns discussed at the Mortality Operational Group have already been highlighted via the incident reporting mechanisms.

1.5 Further work on reporting from SJRs and reporting on learning is ongoing.

1.6 Timelines are provided for the major strands in ongoing mortality work

2. Mortality Indicators

2.1 Performance Indicator Chart: Key National and Local Mortality Indicators

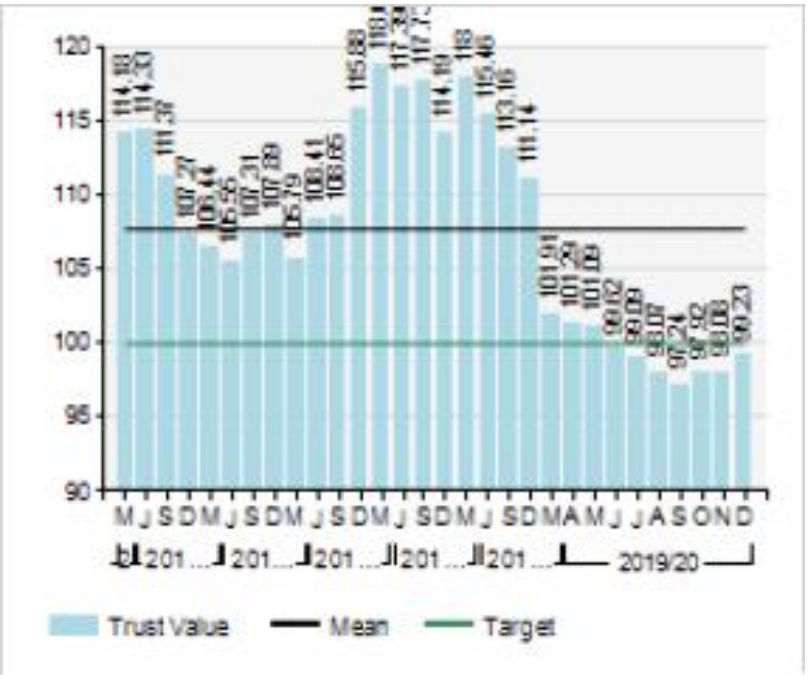
	2019/20											2020/21	Target
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Rolling 12 Month HSMR	98.3	95.6	91.8	89.1	87.0	87.6	86.1	84.5	83.6				100.0
Monthly HSMR	102.1	64.8	73.0	65.0	75.2	82.4	80.0	85.8	81.4				100.0
SHMI	101.1	99.6	99.1	98.1	97.2	97.9	98.1	99.2					100.0
Local HSMR Bronchitis	115.8	114.1	102.2	102.7	84.2	88.1	90.0	82.1	86.2				100.0
Local HSMR LRTI	116.8	115.1	109.9	103.6	84.9	88.9	90.8	82.9	86.9				100.0
Local HSMR Pneumonia	108.3	104.2	98.6	101.2	93.8	96.1	93.2	87.9	79.9				100.0
Local HSMR Septicemia	75.6	75.6	73.1	72.3	71.1	70.3	71.0	72.9	72.3				100.0
Local HSMR Stroke	98.0	95.6	101.0	98.9	104.9	106.5	107.6	100.2	113.5				100.0
Local HSMR UTI	91.7	85.5	76.8	74.7	71.1	60.8	44.1	38.7	32.2				100.0
Local HSMR Acute Renal Failure	113.9	118.1	107.9	117.2	119.3	123.7	121.4	116.2	100.7				100.0
Mortality Screens - %	32.93%	58.33%	89.83%	84.62%	92.06%	90.67%	82.72%	66.67%	65.63%	57.53%	54.76%	10.88%	90.00%
SJRs	2.0	6.0	4.0	8.0	22.0	13.0	8.0	6.0	18.0	13.0	5.0	3.0	0.0
2nd Review	3.0	0.0	2.0	1.0	1.0	1.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0
In Hospital Deaths	82.0	48.0	60.0	52.0	63.0	75.0	80.0	103.0	96.0	73.0	84.0	147.0	77.0
In Hospital Deaths Crude Rate	22.0	18.2	14.8	18.2	23.8	20.6	22.0	31.3	22.1	25.9	36.0	63.9	31.0
LD Deaths	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	2.0	0.0	2.0	1.0	1.0
Sickness Absence Medics	2.08%	1.75%	2.11%	0.57%	0.92%	0.91%	2.71%	1.57%	2.01%	2.06%	2.67%	9.24%	1.00%

This is the first of the quarterly reports, data is available up to April 2020. As reported previously the rise in winter respiratory deaths is reflected in the crude rate and actual numbers for the Nov-Jan period. This has now been joined by the crude rate rises in March and April which are presumed to reflect COVID-19. Further data analysis is under way to confirm this as requested at MOG on June 8th. HSMR data for the trusts higher risk conditions shows a satisfactory trajectory in all areas except Stroke and Renal Failure (AKI). The variation in the AKI figures suggests small numbers of AKI coded in the first FCE – further analysis is underway; the early signals are presented below.

A significant rise is demonstrated in medical sickness absence (4-5 times normal) for the month of April, this reflects the effect of the pandemic on the medical workforce.

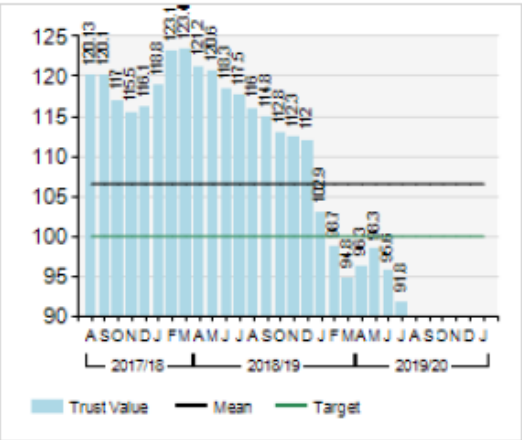
The drop in screening rates is due to the adoption of COVID processes and this should be reversed in subsequent months

2.2 SHMI (to August 19)



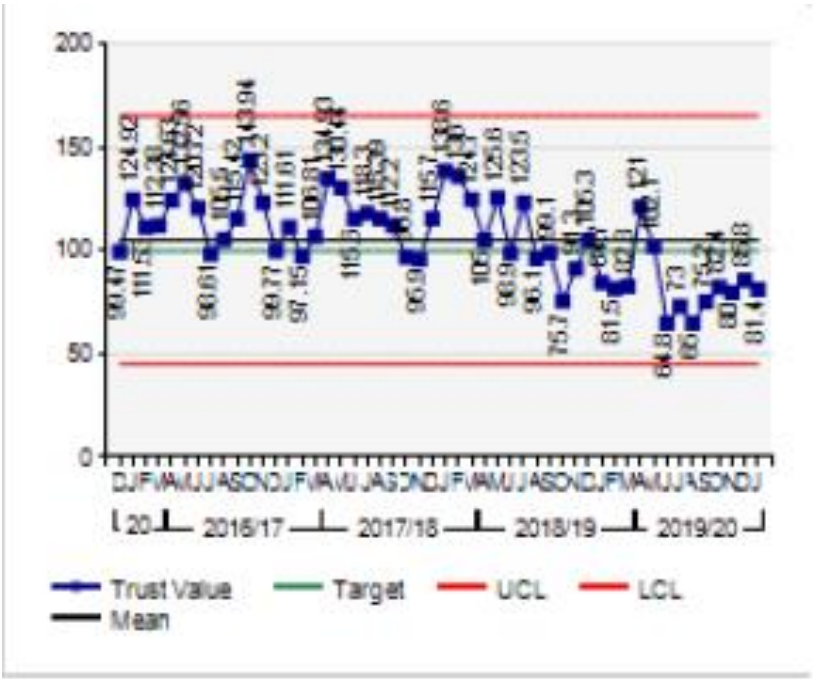
The SHMI has risen to 101.11. This is second lowest in the North West region after Lancashire Teaching Hospitals NHS Foundation Trust. SHMI has risen for all local trusts, this appears to be related to an increase in respiratory illness in the region over the previous winter.

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



The rolling HSMR remains in a satisfactory position. HSMR and SHMI differ in their methodologies. One important difference is the removal of palliative care deaths from the HSMR calculation (while still present in the calculation of SHMI). The proportion of patients receiving palliative care at the end of life has risen to around 60% of all deaths. This may go some way to explaining the differences in HSMR and SHMI.

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

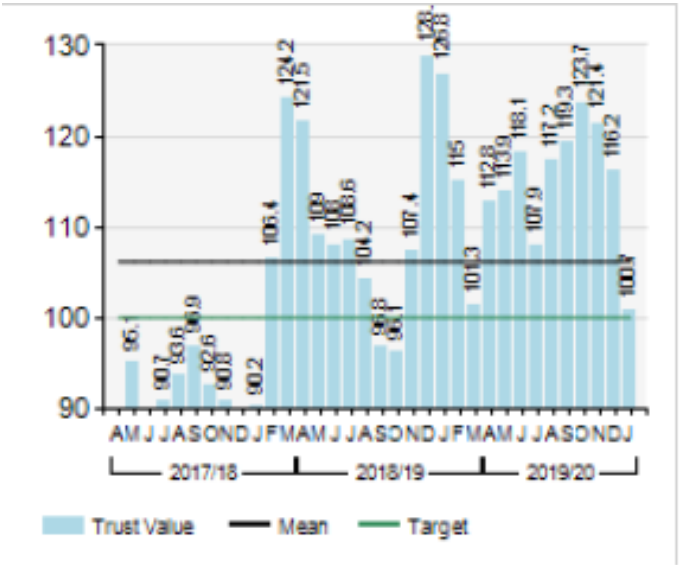


Monthly HSMR has stabilised in recent months around 80-90. This is improved against the historical overall position.

Diagnosis Groups

AKI. Two areas being reviewed:

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



The review of deaths of AKI patients is ongoing.

Early findings:

14 patients who died were coded as AKI on their first consultant episode (i.e they presented to hospital with an AKI as the primary condition treated. These relatively small numbers explain the variability in the graph above.

6 deaths have been reviewed so far.

a) Age range 81-92
b) 2/6 main condition treated was AKI, others include Ca prostate, neurological failure of cause unknown, gastroenteritis and sepsis.
c) AKI improved with treatment in 4/6 patients, non-improving patients had significant malignancy.
d) All patients presented with significant AKI 3.
e) Good care in the first 24 hours, early imaging important in management.
f) Daily medical review evidenced
g) Appropriate non-escalation decisions in all 6 patients

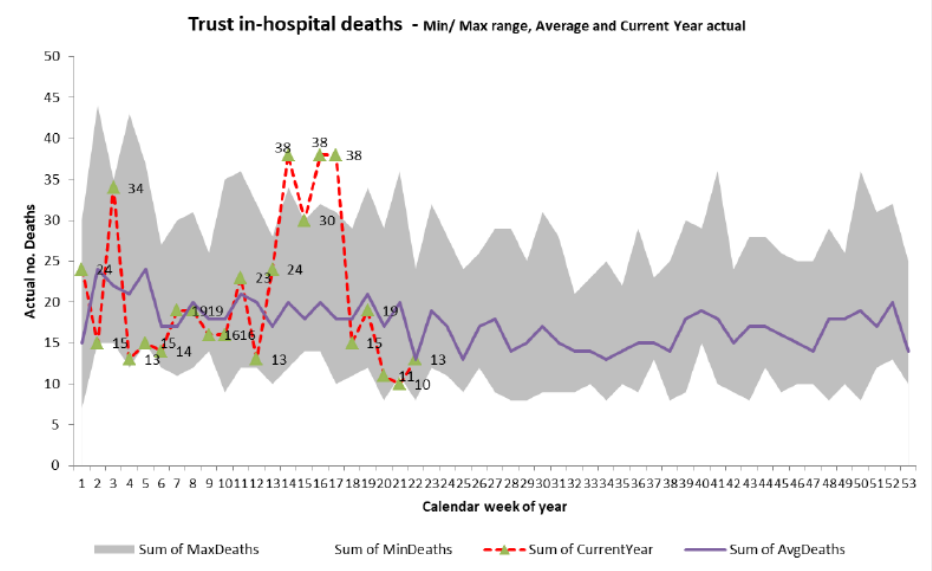
h) Evidence of good family discussions in all cases.
i) Cancer diagnosis in 3/6
j) Dementia diagnosis in 2/6
k) Delays in pharmacy AKI review (all nephrotoxics stopped on admission)
l) Weekend delays for imaging (USS)
m) Rational for non-intervention in advanced frailty needs better documentation by medical teams.
n) 0/6 deaths avoidable
o) 2/6 possible avoidable admissions with ACMP usage.

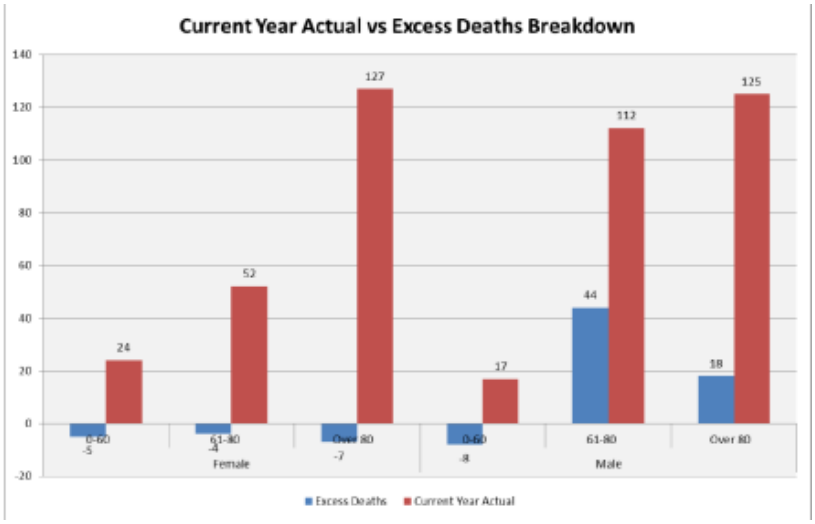
When this review is formally completed the results will be presented in subsequent reports together with recommendations for action.

Covid-19

Presented below is the rolling weekly death rate in the trust. The line for the current year shows a significant rise above the maximum rates in the past 5 years (shown by the grey shaded area). This was sustained over the course of 4 weeks before dropping below the average of the previous 12 months in May. This represents both the height of the COVID pandemic and the rapid decline in cases while the trust was yet to encounter usual business. Crude death rates now seem to have returned to usual rates.

The second graph demonstrates the age/sex distribution. Excess deaths refers to the amount of deaths the trust encountered above or below average. It cam be seem that while on average, female deaths are reduced, deaths amongst males between 61 and 80 show a substantial increase.





3. Mortality Improvement Activity

The Deteriorating patient project is now reported on through a separate reporting line and is no-longer part of this report

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

4.1 Screening

Southport and Ormskirk Hospital NHS Trust

Screening

							Overall Assessment Rating per Month						
Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review	No reviewed	% reviewed	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care	N/A - Not Stated
Apr-19	91	33	36.3%	6	18%	6	100%	2	4				
May-19	82	25	30.5%	4	16%	4	100%		2	2			
Jun-19	48	27	56.3%	11	41%	8	73%	1	3	2	2		
Jul-19	59	52	88.1%	11	21%	9	82%	1	5	2			1
Aug-19	52	44	84.6%	13	30%	10	77%	1	3	5	1		
Sep-19	63	57	90.5%	18	32%	14	78%	2	6	6			
Oct-19	75	68	90.7%	19	28%	15	79%	1	9	4	2		
Nov-19	81	66	81.5%	15	23%	12	80%	4	4	2	2		
Dec-19	102	67	65.7%	25	37%	14	56%	2	3	7	1		
Jan-20	96	64	66.7%	20	31%	11	55%	1	6	4	1		
Feb-20	73	42	57.5%	13	31%	6	46%		2	4			
Mar-20	84	46	54.8%	11	24%	2	18%		2				
Apr-20	147	16	10.9%	1	6%		0%						

The screening rate has deteriorated in the last three months and action on this is being taken with a publication of the screening figures in an effort to raise awareness and improve performance in our recovery from COVID-19. The pandemic mortality processes adopted account for the deteriorated position in April, however the situation has existed prior to this.

Efforts to recover performance will be based around awareness raising and ongoing feedback on performance.

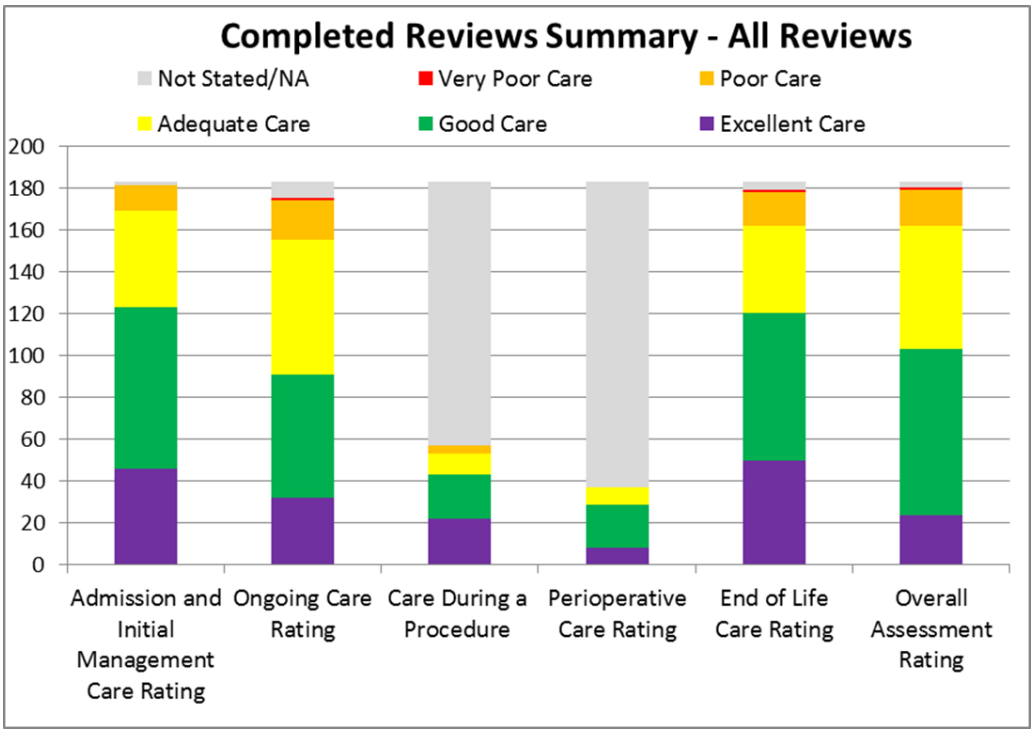
The ultimate solution to robust mortality screening is the Medical Examiner Project.

4.2 First Structured Judgement Review

Completed First Structured Judgement Reviews

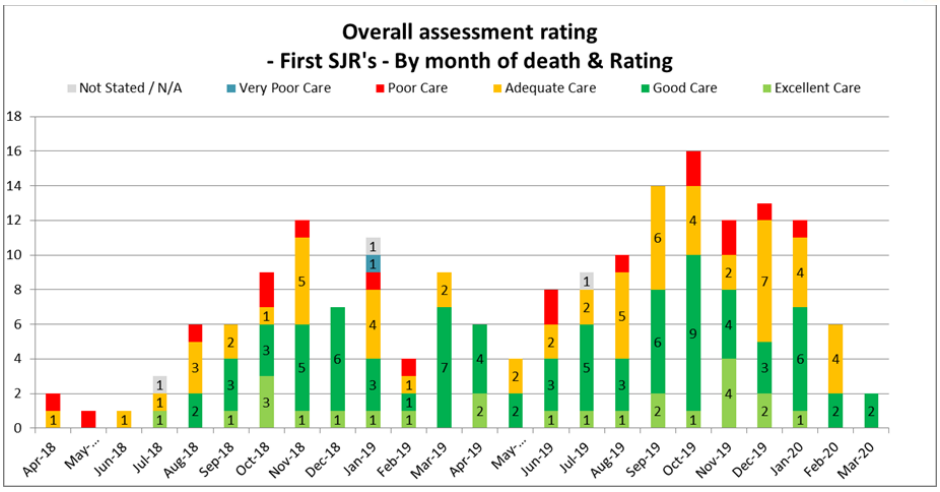
	2018						2019												2020					Grand Total
Specialty	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
General Medicine				4	4	1	1	1	2	2				1	5	3	1	2	4	3	1	2	2	39
Geriatric Medicine			1	3	1	2	1	3	2		1		1	1	3	1	1	1	5	2		1	4	34
Intensive Care/Coronary Care/High Dependency	1	2	1	3	1	1	1		3		1	2	1		2	1				3			1	24
Cardiology				2								2	1	1	2			1	6	4	1	1	2	23
Respiratory Medicine/Thoracic Medicine					1				2	2		1		2	3	1	2		3				1	18
Trauma & Orthopaedics		1	1	1									1		5	5			1		1			16
Stroke						2								1	1		2	2	1	1	1		1	12
Gastroenterology							1			1						2		1						5
Endocrinology														1			1				1		1	4
Urology								1				1			1									3
Rehabilitation																				1			1	2
Urgent Care														1			1							2
Medical Director																							1	1
Respiratory Therapy																							1	1
Grand Total	1	3	3	13	7	6	4	5	9	5	2	6	4	8	22	13	8	7	20	14	5	4	15	184

SJR completion saw a reduction in March and April, this is likely a combination of the workload required for COVID preparation and the sickness absence rate. The recovery in May 2020 to the third highest monthly total on record is due to the lower clinical workload in May and shielding of staff who can contribute to SJR reviews. The grand total of 184 reviews keeps us in line with the overall target of 10-20% of deaths undergoing SJR review.

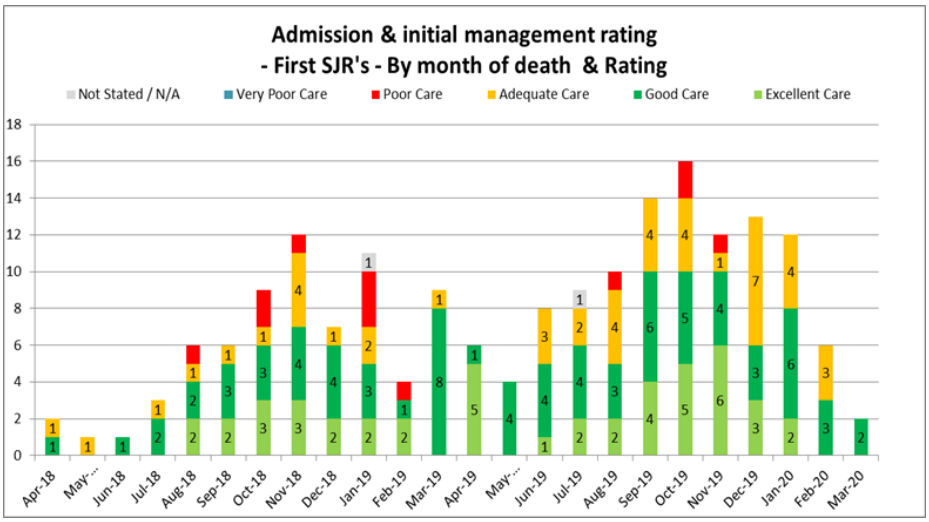


The trust-wide graph of quality of care again highlights that inpatient care after the first 24 hours is most likely to be considered less than ‘good’. It is important that quality improvement work is targeted in this area going forward.

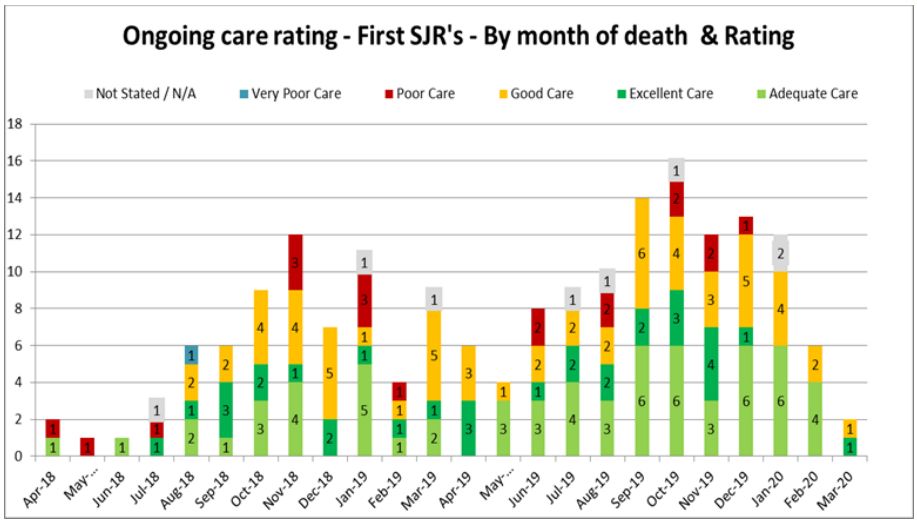
A thematic analysis of excellent vs poor ongoing care will be produced for the next report.



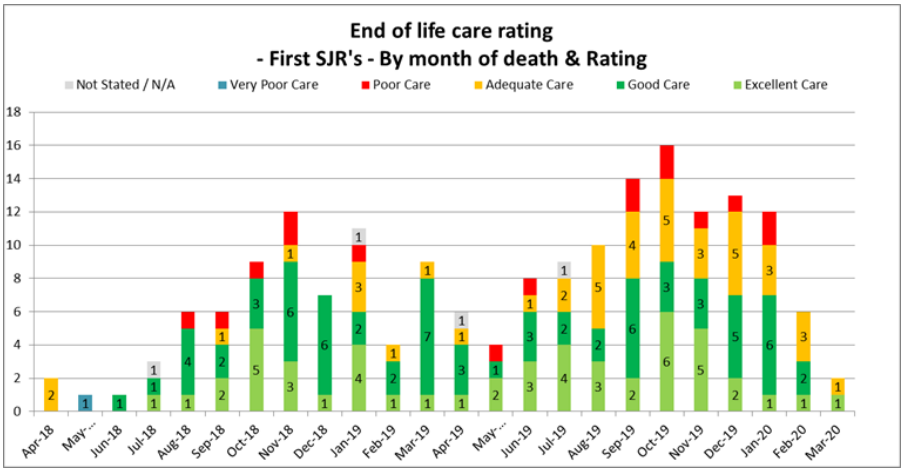
Looking at the trend over time, Overall there has been an increasing number of reviews, with more reviews done over the winter period, presumably due to the general increase in the number of deaths at this time. Allowing for this, overall assessment of care has not obviously changed.



Sub-dividing, it would appear that allowing for increased numbers, the chance of receiving good or excellent care in the first 24 hours has improved. Poor care is more likely in the winter months when resource is stretched and supply/demand mismatch is most evident. This aligns with the mortality data report.



Ongoing care shows relatively static performance over time.



Of concern, end of life care shows a deteriorating performance over time, with 'adequate' care more prevalent. This is surprising given the raising of awareness and work that has gone into this area of patient care. This may represent a shifting in reviewers' attitudes to end of life care over time. Further analysis will be performed.

4.3 Second Structured Judgement Review

	Number of completed First SJR's	Number requiring a second SJR	Number of completed Second SJR's
General Medicine	39	6	5
Geriatric Medicine	34	1	1
Intensive Care/Coronary Care/High Dependency	24	4	2
Cardiology	22	4	2

Respiratory Medicine/Thoracic Medicine	19	3	3
Trauma & Orthopaedics	16	1	1
Stroke	12		
Gastroenterology	5		
Endocrinology	4		
Urology	3		
Urgent Care	2		
Rehabilitation	2		
Medical Director	1		
Grand Total	**183**	**19**	**14**

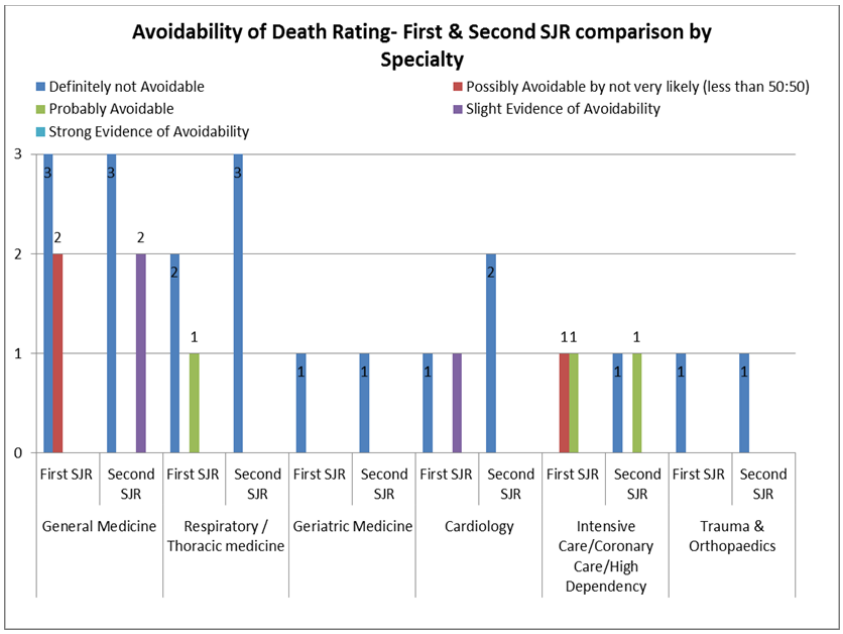
There are 5 of 15 second reviews outstanding. All 14 completed SJR 2 reports have been discussed at MOG. 7 cases were discussed at Junes meeting. No further cases have been classified as avoidable by the committee. It was noted that all cases with concerns had already been highlighted via the risk management system.

Themes:

- Clinical ownership - risk of patients falling between specialties in 'shared care' situations
- Delay to imaging – importance of making a diagnosis to appropriate care
- Decision making at the end of life – stopping unnecessary interventions
- Appropriate coronial referrals – internal guidance and ME role
- Appropriate admissions to hospital – ACMP usage
- Appropriate admissions to hospital – ACMP not followed in community
- Delayed discharge – system issues with intermediate care.
- Delayed urgent operation due to unnecessary extra investigations (echo in NOF)
- Lack of clarity to clinical pathways – UGI bleeding / emergency endoscopy

These issues will form a separate learning bulletin to staff. Many of these issues are system problems and require a system wide approach.

4.4 Avoidability



This table is cumulative and represents all the completed first and second SJR opinions on avoidability of death. There remains one previously reported death which in the opinion of the mortality reviewers was more than 50% likely to have been avoidable. These and other cases have been analysed through the risk management system which may reach an alternate opinion. Avoidability is a contentious topic and the judgement is frequently subjective.

5. Next Steps

Again, the supply / demand mismatch situation that reduces the effectiveness and safety of patient care remains relevant. Discussions have occurred with AED and Information as to how best examine the association between time spent in AED and mortality. AED deaths are now reported monthly to MOG. This issue is complex and will require clinical review of cases to understand further.
Estimated completion December 2020

Analysis is being sought from the Microbiology department of this winters' respiratory pathogens to see if this accounts for the rise in mortality.
Estimated completion July 2020

Analysis of AKI deaths is progressing with two cohorts – AKI on arrival and AKI as an inpatient.
Estimated completion August 2020

Examine and define the output from a departmental mortality meeting.
Estimated completion October 2020

Devise a system for reporting themes from the subjective data in completed SJR reviews, both upwards and to the shop floor.
Estimated completion August 2020

6. Standing Recommendations

Ensure proactive monitoring of capacity and demand within the system occurs; those performing this monitoring must be clear that decisions taken to manage surges in demand have real consequence on patient mortality. Include measures to increase clinical capacity and measure to reduce demand.

Continue to evaluate and invest in activity which provides capacity to manage serious illness quickly and aggressively to reduce complications and length of stay.

Encourage and support interventions which support staff to work reliably and consistently, with minimal variation, such as through the adoption of appropriate IT or best practice pathways which are clear and available.

Support ward processes and ward care with the same intention as supporting AED in order to improve the quality of patient care and thereby improve flow and improve safety. Start by engaging with ward teams such as junior medical staff and junior nurses to understand the issues they face.

Southport and Ormskirk Hospital NHS Trust

Quarter 2 Report

1. Executive Summary

- HSMR, which excludes palliative care deaths and deaths after discharge remains in a good position. SHMI which includes these deaths is within expected norms but above 100, this is likely due to COVID-19 exclusions.
- Work to examine the diagnosis group of 'fluid and electrolyte disorders' and deaths after discharge is ongoing.
- SJR trend over time analysis shows a general improvement in reviewers' opinion of quality of care. The previously reported issue with end of life care appears to have stabilised.
- Two probably avoidable deaths have been highlighted in Q2. These have already been reported to the risk management system.
- Further work on reporting from SJRs and reporting on learning is ongoing.
- Timelines and updates are provided for the major strands in ongoing mortality work.

2. Mortality Indicators

2.1 Performance Indicator Chart: Key National and Local Mortality Indicators

	2019/20						2020/21						Target
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Rolling 12 Month HSMR	87.6	86.1	84.5	84.1	82.8	81.4	81.1	79.9	80.9				*100.0*
Monthly HSMR	82.4	80.0	90.2	81.4	73.7	90.3	130.9	89.3	73.8				*100.0*
SHMI	97.9	98.1	99.2	101.0	102.2	103.8	103.9	102.3					*100.0*
Local HSMR Bronchitis	88.1	90.0	80.9	85.8	103.9	104.0	100.8	98.9	103.2				*100.0*
Local HSMR LRTI	88.9	90.8	81.7	86.4	104.6	93.8	101.5	99.1	103.9				*100.0*
Local HSMR Pneumonia	96.1	93.2	88.5	81.2	79.7	80.9	78.4	80.0	81.3				*100.0*
Local HSMR Septicemia	70.3	71.0	72.9	71.3	73.9	71.0	68.3	69.9	71.3				*100.0*
Local HSMR Stroke	106.5	107.6	100.0	111.4	104.4	102.7	103.3	105.7	105.2				*100.0*
Local HSMR UTI	60.8	44.1	42.7	51.2	49.8	62.9	68.5	63.1	72.1				*100.0*
Local HSMR Acute Renal Failure	123.7	121.4	98.3	77.6	73.4	72.5	66.5	65.5	64.9				*100.0*
Mortality Screens - %	90.67%	82.72%	66.67%	66.67%	57.53%	54.76%	17.01%	28.33%	14.75%	75.93%	48.33%	0.00%	*90.00%*
SJRs	13.0	8.0	6.0	18.0	14.0	5.0	3.0	23.0	18.0	29.0	31.0	3.0	*0.0*

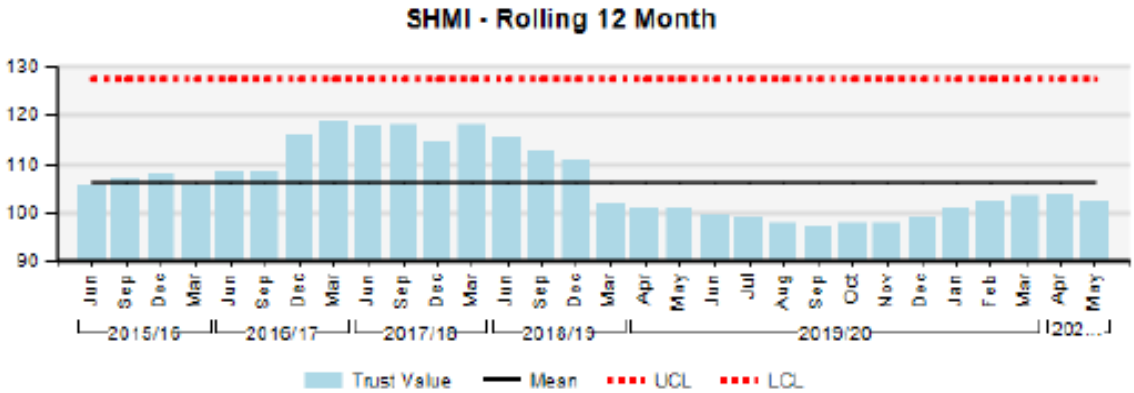
2nd Review	1.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	1.0	5.0	2.0	0.0	*0.0*
In Hospital Deaths	75.0	80.0	103.0	96.0	73.0	84.0	147.0	60.0	61.0	54.0	60.0	56.0	*77.0*
In Hospital Deaths Crude Rate	20.6	22.0	31.3	22.0	25.8	35.9	63.6	22.5	22.5	24.5	21.2	29.1	*31.0*
LD Deaths	0.0	0.0	1.0	2.0	0.0	2.0	1.0	1.0	0.0	0.0	1.0	0.0	*1.0*
Sickness Absence Medics	0.91%	2.71 %	1.57 %	2.01 %	2.06 %	2.67 %	9.24%	3.12 %	2.20 %	1.88 %	2.19 %	2.18 %	*1.00 %*

This is the learning from deaths report for Quarter 2 of 2020-21. The data presented in the overview above supports the contention in the previous report, and the view of MOG, that this is dominated by the effects of COVID-19. The large rises seen in crude mortality is seen to fall off again as the first wave subsides. This pattern will be expected in subsequent waves. The diagnostic groups involved also reflect the impact of a pandemic respiratory virus. Even though COVID-19 itself is removed from the mortality data, it is accepted that the diagnostic tests are not completely accurate, and therefore not all will be removed. It is also noted that the SMR for stroke is elevated. It has been commented on before that HSMR is not a specific stroke SMR, the SSNAP audit is the preferred measure and reports annually, on the last report presented to MOG the SSNAP mortality was in the expected range. It is also noted that a link between the coagulation disorder caused by COVID-19 and increased embolic stroke rate and severity has been described.

The SMR for AKI has improved and this will be discussed later in this report.

Of greatest concern is the failure to reverse the decline in the rate of mortality screening from wave 1. This will be discussed below.

2.2 SHMI (to May 2020)



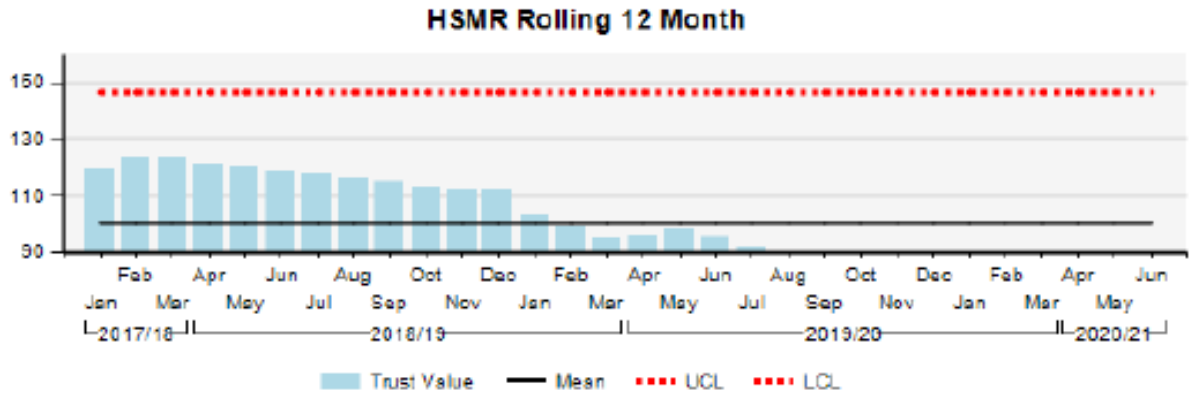
We have seen a rise in the SHMI above 100 for the previous few months. The last report shows a marginal fall. The analysis of this by the information department and reviewed by MOG

suggests that this has been affected adversely by the removal of all COVID-19 spells from the dataset. This affects both the expected deaths and the observed deaths in complex and unpredictable ways. The conclusion is that the reliability of the SHMI as an overall measure of mortality is reduced. That said, increased testing and diagnostic certainty may allow the amount of exclusions to stabilise with greater certainty over the remaining dataset.

Despite these issues, the rise in SHMI remains within confidence intervals, and thus, mortality on this model is considered 'as expected'.

Further analysis of the SHMI has raised deaths within 30 days post discharge, deaths post fractured neck of femur and deaths from electrolyte disorders as areas for further analysis, which has begun.

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

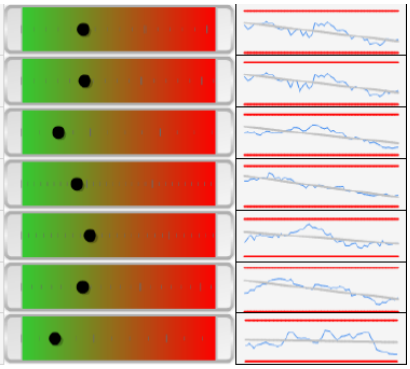


The following is a general position statement on rolling HSMR which remains correct when considering Q2 data. HSMR and SHMI differ in their methodologies. One important difference is the removal of palliative care deaths from the HSMR calculation (while still present in the calculation of SHMI). The proportion of patients receiving palliative care at the end of life has risen to around 60% of all deaths. This may go some way to explaining the differences in HSMR and SHMI.

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

The isolated rise in monthly HSMR for April reflects the COVID-19 pandemic, otherwise the trend remains satisfactory.

2.5 Diagnosis Groups

Local HSMR Bronchitis	Diagnosis Level HSMR	100.0	103.2				
Local HSMR LRTI	Diagnosis Level HSMR	100.0	103.9				
Local HSMR Pneumonia	Diagnosis Level HSMR	100.0	81.3				
Local HSMR Septicemia	Diagnosis Level HSMR	100.0	71.3				
Local HSMR Stroke	Diagnosis Level HSMR	100.0	105.2				
Local HSMR UTI	Diagnosis Level HSMR	100.0	72.1				
Local HSMR Acute Renal Failure	Diagnosis Level HSMR	100.0	64.9				

The above is taken from the mortality dashboard. As can be seen, mortality rates for the key conditions monitored at MOG are improving.

AKI

AKI mortality has been the subject of interest, The SMR for this has improved, the likely cause of this is the better identification of AKI generally in the hospital population through the clinical review process. This means better documentation of the presence of AKI in both surviving and non-surviving patients. This improvement in data quality allows better focus on the important issues.

As discussed in the previous report, the cohort of patients with AKI on presentation usually presented with a significant pathology other than AKI (i.e. the AKI was the secondary issue) the AKI frequently improved, but the primary condition was often the cause of death. From a holistic perspective, the management of severe chronic illness, severe frailty and planning for deterioration prior to deterioration in the community were clear themes.

Given the widening of the scope, the improved SMR and the emergence of other linked issues, this work has been evolved to another project. AKI treatment itself will now be monitored through the AQ audit rather than mortality per se.

Deaths 30 days post discharge

This contributes around 40% to the trust's mortality (national average 32%). A process has been implemented for GPs to contact the trust if a patient dies post discharge and they have concerns, to date no concerns have been raised. The mortality dashboard demonstrates that there has been significant improvement in the length of hospital stay. The dashboard also shows a rise in mortality post discharge, however the factors underlying this are yet unknown.

To investigate this further:

- The dashboard now reports on the number of readmissions after an unplanned admission.
- A cohort of these patients has been identified and will be clinically reviewed.

Southport and Ormskirk Hospital NHS Trust

Fluid and electrolyte disorders

This has been highlighted as a diagnosis group with an elevated mortality. A cohort of cases has been identified (12 months-worth, 49 cases) and is being clinically reviewed. It is clear from initial work, that this is finding similar themes to the AKI review, and thus this has superseded that work as explained above.

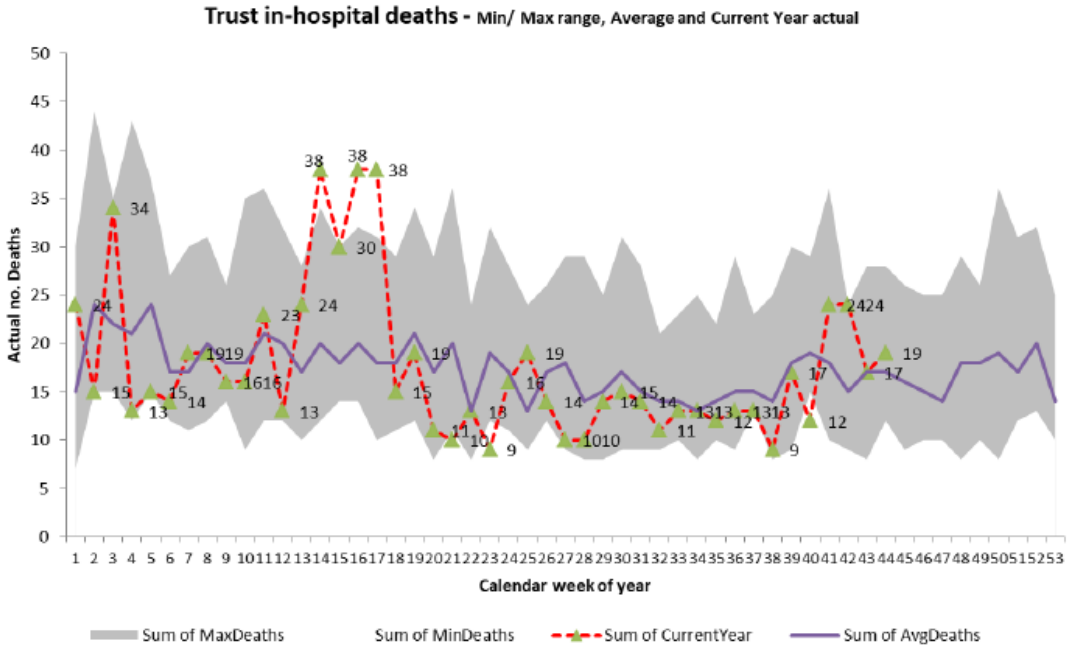
Fractured Neck of Femur

This diagnosis has been raised as an issue. On further analysis this was caused by a cluster of deaths in April 2020. These deaths have received an SJR review. A thematic analysis will be performed and presented to the joint Anaesthetic / Orthopaedic audit meeting on the 19th of November and subsequently to MOG.

COVID-19

As COVID-19 is largely excluded from the standardised mortality instruments we are monitoring crude mortality rates. The graph below is the trust's monthly crude mortality set against the backdrop of the average of the past 5 years. As can be seen, the first wave represents a large rise in crude mortality which returned to a better than average position subsequently. The building second wave is seen to emerge on the right of the graph as a rise in excess deaths.

Learning from wave 1 has been conducted in the form of an SJR-based analysis of deaths. 40 deaths from wave 1 have been analysed. These reviews are complete. The report is being compiled by Dr Andrew Kent, retired consultant in anaesthesia and intensive care medicine on behalf of the trust. This process has been delayed due to a re-organisation within the integrated governance department.



Southport and Ormskirk Hospital NHS Trust

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

3.1 Screening

Screening

	No of in hospital deaths	No of in hospital deaths screened	%	No of not in hospital deaths screened	Total Number of deaths screened	No triggering for review	% Triggering for review	No Reviewed	% Reviewed	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care	N/A - Not Stated
Oct-19	75	69	92.00%	6	75	20	26.67%	20	100.00%	2	10	5	3		
Nov-19	81	66	81.48%	5	71	17	23.94%	17	100.00%	5	7	3	2		
Dec-19	102	67	65.69%	17	84	27	32.14%	27	100.00%	5	11	9	1		1
Jan-20	96	64	66.67%	10	74	23	31.08%	22	95.65%	2	11	6	3		
Feb-20	73	43	58.90%	10	53	13	24.53%	11	84.62%		5	5	1		
Mar-20	84	46	54.76%	14	60	18	30.00%	15	83.33%	2	8	3	1		1
Apr-20	147	29	19.73%	7	36	30	83.33%	29	96.67%	10	12	6	1		
May-20	60	17	28.33%	4	21	13	61.90%	13	100.00%	1	9		2	1	
Jun-20	61	9	14.75%	2	11	4	36.36%	3	75.00%			2		1	
Jul-20	54	40	74.07%	3	43	13	30.23%	13	100.00%		5	6	2		
Aug-20	60	31	51.67%	9	40	7	17.50%	6	85.71%		1	4	1		
Sep-20	56	11	19.64%	10	21	2	9.52%	1	50.00%		1				
Oct-20	87	1	1.15%	13	14	4	28.57%	0	0.00%						

As can be seen, the screening rate was recovered to 74% in July 2020 following the end of the first wave. However, this has dropped off substantially since.

The causes are:

- Junior doctor change-over in august 2020.
- The configuration of the bereavement suite preventing social distancing.

The options to improve this in the immediate term are limited. Mortality processes are focused within the bereaved suite and changing this will require concerted effort and resource. This would then be reversed once the Medical Examiner's Office becomes operational, thus the preferred option is to continue with the current process as best as possible until the ME system goes live.

Two interim ME's, Dr Patrick Macdonald and Dr Chris Goddard are performing ad hoc reviews, supported by interim MEO Mrs Mandy Power.

Issues for completion:

- HR advice regarding ME appointments (trust aim is to appoint 10)
- MEO JD requires approval. The ME office does not function without this.
- Refurbishment of the dissection room on the mortuary corridor as the ME office. This work is to begin imminently.

3.2 First Structured Judgement Review

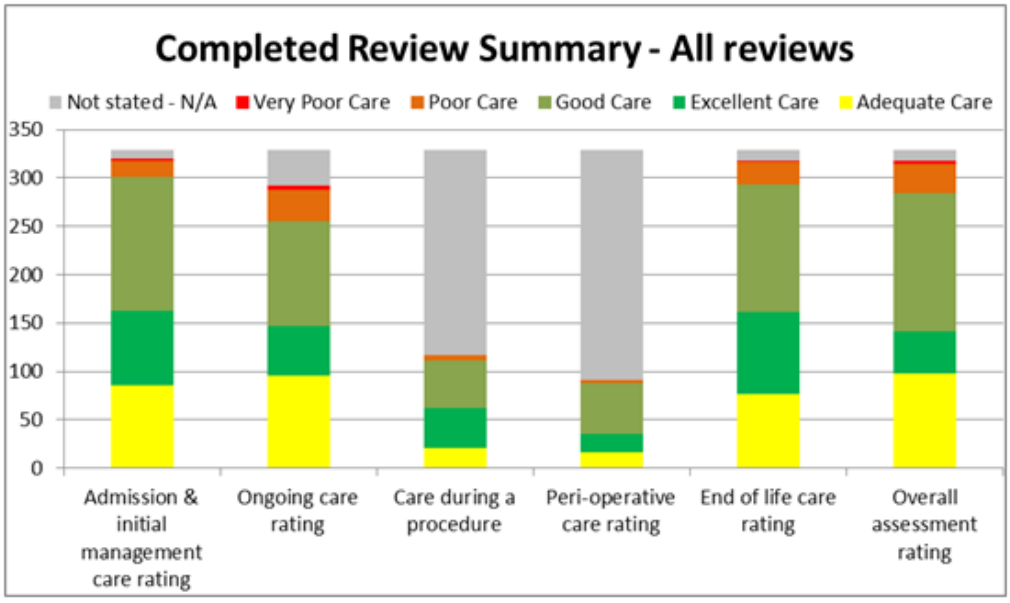
NHS
Southport and Ormskirk Hospital
NHS Trust

Completed First Structured Judgement Reviews

	2018											2019												2020									Grand Total
	Jan	Mar	Apr	May	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	Aug	Sep	
General Medicine		1	2	1			1	2		4	1	3		2	1	1			6	3	5	3	6	6	5	4	10	3	1	7	5		83
Intensive Care/Coronary Care/High Dependency					1	2	2	4	3	1				2		2	3	2	2	2	2	2	7	4	2	3	10	4			1		61
Geriatric Medicine					1	1	1		2	3	2	3	2		2			1	2	2	5	3	4	2	1	1				1			39
Respiratory Medicine/Thoracic Medicine									1	1		4	1	2	1			1	3	2	3	2		1	1	1	1	2					27
Cardiology	1								2					1	1		2	2		2	1	4	7	3	1			1		1			29
Trauma & Orthopaedics							2	1	2		1	1		2			1	3		2	1		1			1	4			1			23
A&E									1										2	1		2	2	1		3	3	1	1				17
Stroke										2	1					1		1		3	2	1		2									13
Gastroenterology											1		1				1			1	1					1		1	1	3			11
General Surgery							1		1			1					1			1								1	1					7
Endocrinology										1		1						1						2										5
Urology												1				2	1															1	5
Urgent Care											1	1	2				1																	5
Respiratory Therapy																									1	1								2
Rehabilitation															1									1										2
Grand Total	1	1	2	1	2	3	7	7	12	12	7	15	6	9	6	6	10	11	15	19	20	17	27	22	11	15	29	13	3	13	6	1	329

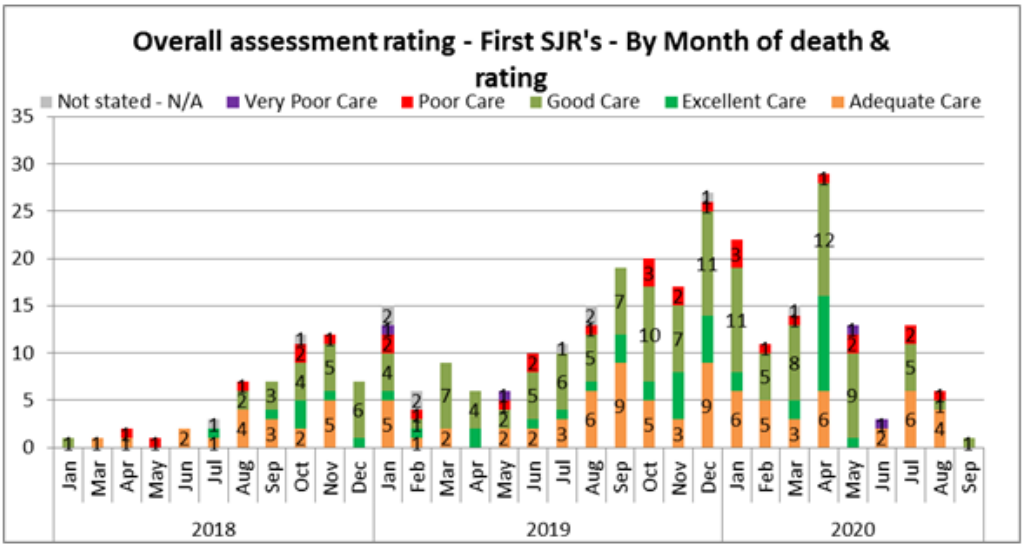
The above graph shows the first SJRs done by month of death. As can be seen 29 reviews have been done for the month of April at the height of the first wave.

Of note, 329 reviews have now been completed over the course of 3 years, which is within the target set (10-20%) of all deaths.



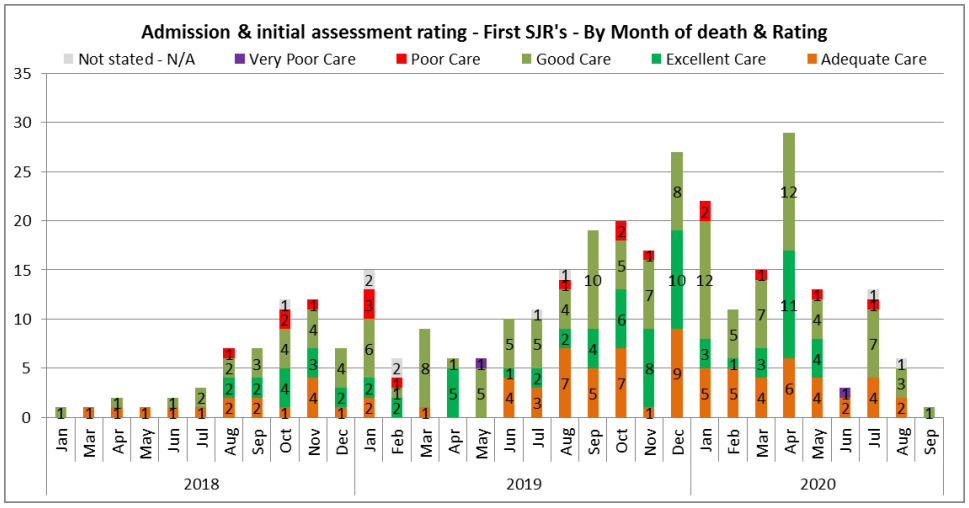
The trust-wide graph of quality of care demonstrates in improvement in the chances of ongoing (or ward level) care being judged good, excellent or adequate. While this still remains our weakest area, there is evidence of improvement over time.

A thematic analysis of excellent vs poor care in each area is still planned.

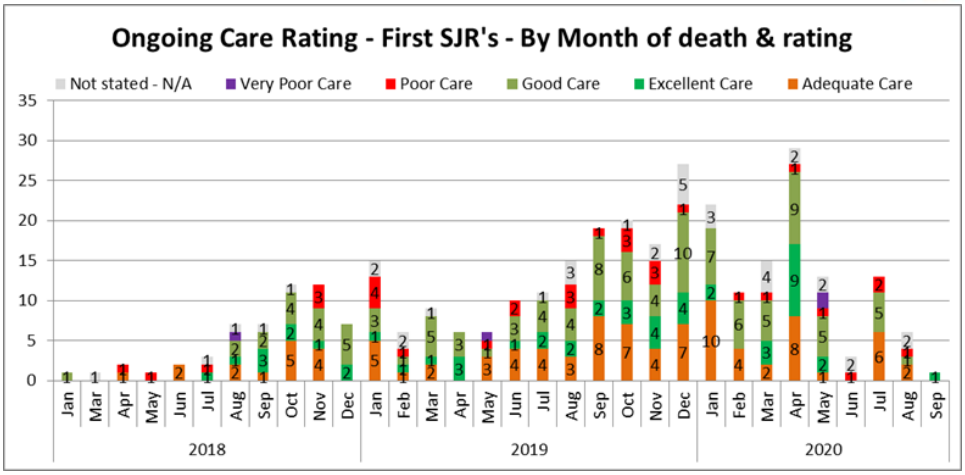


Trend over time would also seem to support an improvement in the rated quality of care, with all categories increasing except poor and very poor.

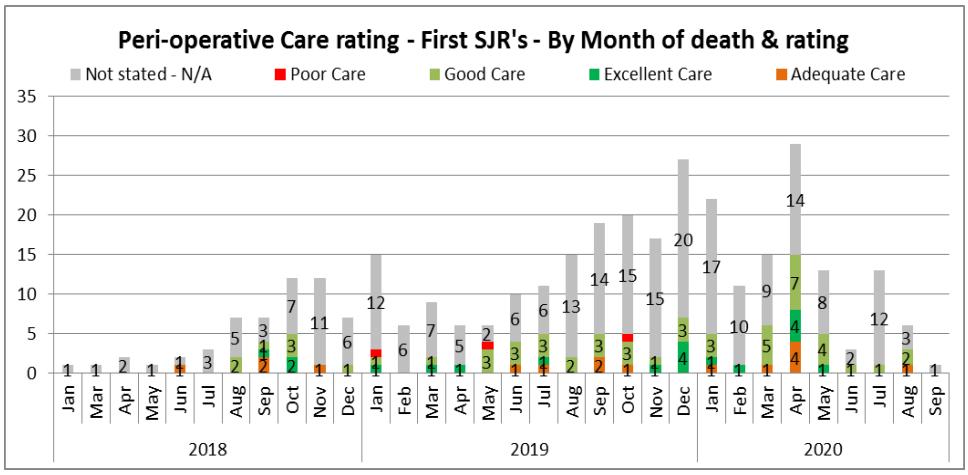
Sub-dividing, it would appear that allowing for increased numbers, the chance of receiving good or excellent care in the first 24 hours has shown sustained improvement.



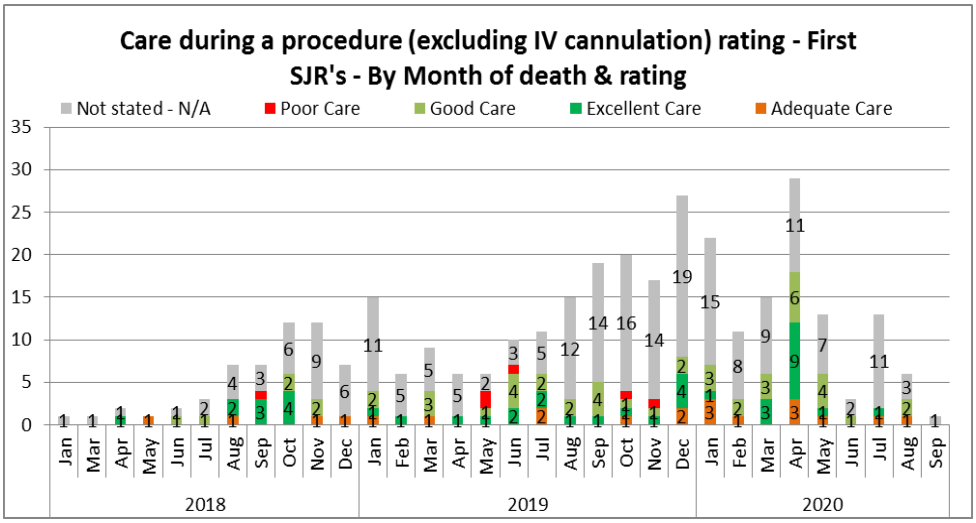
As discussed above, ward level care has seen a greater proportional increase in adequate, good and excellent than in poor or very poor, showing a gradual improvement



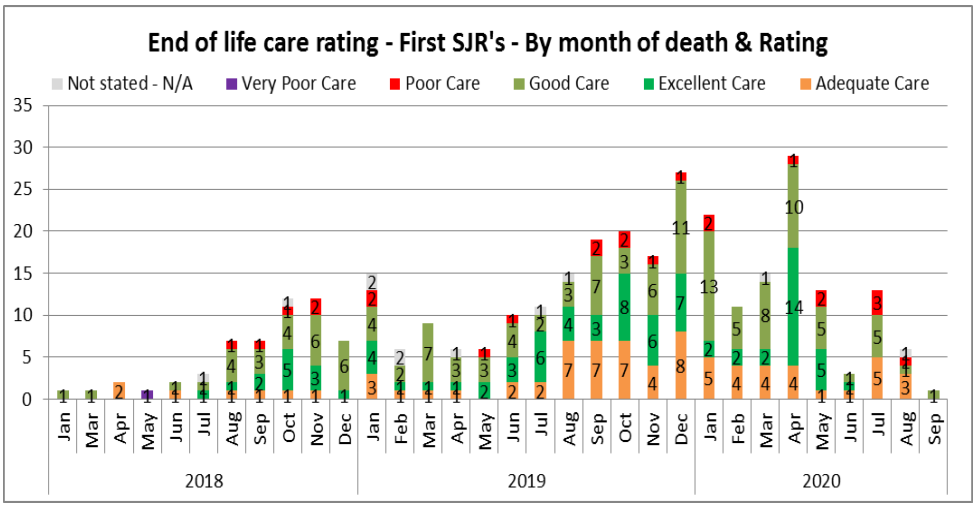
Peri-operative care, when relevant shows no poor or very poor care in 2020.



Care during a procedure shows a similar trend.



Again, end of life care shows a greater proportional rise in good rather than poor, however the challenge here is to convert adequate to good.



3.3 Second Structured Judgement Review

	Number of completed First SJR's	Number requiring a second SJR	Number of completed Second SJR's
General Medicine	82	13	10
Intensive Care/Coronary Care/High Dependency	61	6	2
Geriatric Medicine	39	1	1
Respiratory Medicine/Thoracic Medicine	29	4	4
Cardiology	29	5	3
Trauma & Orthopaedics	23	2	1
A&E	17	1	1
Stroke	13	1	1
Gastroenterology	11	1	1
General Surgery	7	1	1
Endocrinology	5		

Urgent Care	**5**		
Urology	**4**	**1**	
Rehabilitation	**2**		
Grand Total	**327**	**36**	**25**

36 second SJRs have been completed in total and discussed at MOG. In Quarter 2, one probably avoidable death has been reported and is awaiting review at SIRG.
STEIS investigations on two deaths occurring in Q1 have been completed in Q2, both of these are categorised as probably avoidable (cardiac arrest after alcohol intoxication in ED and a death after drainage of large amounts of ascitic fluid without albumin replacement).

The trust has identified 5 probably avoidable deaths since SJR reviews began in 2018, with 2 in Q2 of 2020-21.

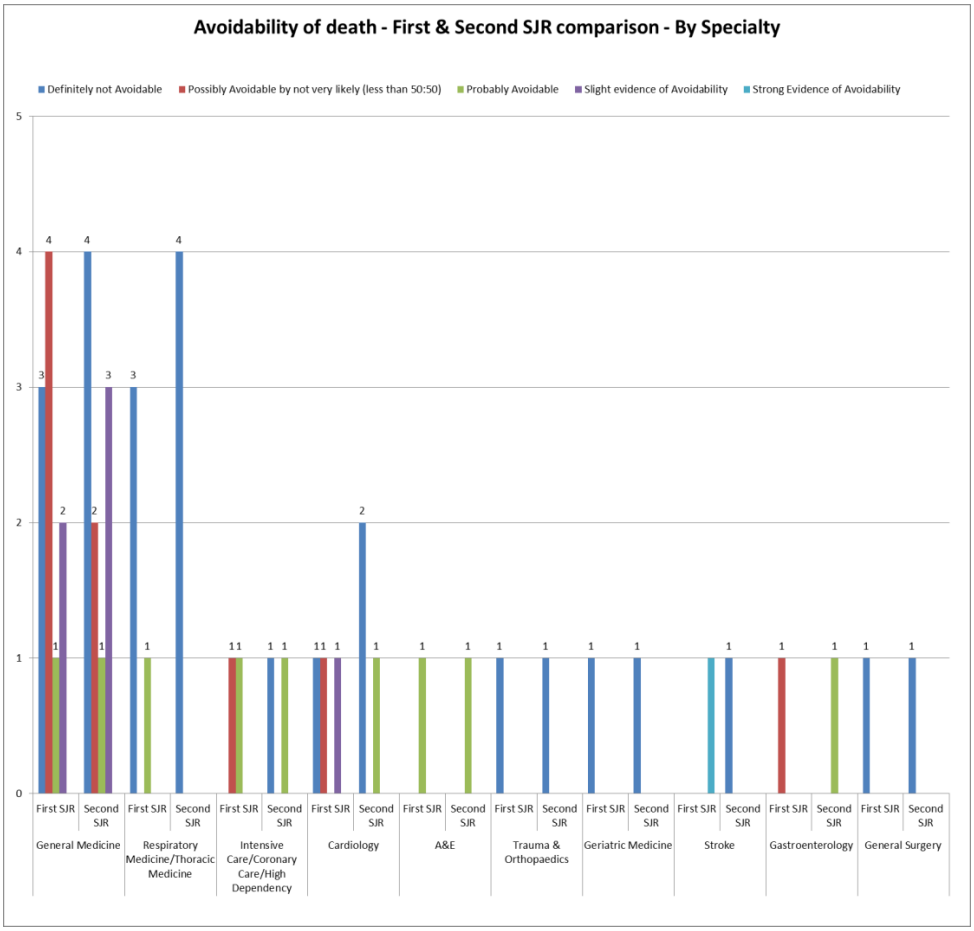
All deaths considered avoidable on SJR in the past 12 months have been recorded on the incident system management system and considered at SIRG prior to review at MOG.

Themes:

- Recognition of those likely to be dying and communication of this.
- Communication with those close to the patient regarding clinical status and prognosis, especially during restricted visiting.
- Leadership of care when multiple teams are involved, shared care creates problems of ownership and clarity must be given over which team takes the lead in a given circumstance.
- Clarity over the required observations in circumstances such as reduced level of consciousness and after invasive procedures.
- The importance of correct placement of patients requiring specialty care.
- Standardised, clear pathways for high-risk invasive procedures.
- Fluid balance and response to hypotension and a reduced urine output.

These issues will form a separate learning bulletin to staff. Many of these issues are system problems and require a system wide approach.

3.4 Avoidability



This table is cumulative and represents all the completed first and second SJR opinions on avoidability of death. As discussed above, these 5 cases have been analysed through the risk management system which may reach an alternate opinion. Avoidability is a contentious topic and the judgement is frequently subjective.

4. Next Steps

Again, the supply / demand mismatch situation that reduces the effectiveness and safety of patient care remains relevant. Discussions have occurred with AED and Information as to examine the association how best between time spent in AED and mortality. AED deaths are now reported monthly to MOG. This issue is complex and will require clinical review of cases to understand further.

Estimated completion December 2020
Update Nov 2020:
A subset of patients who have been readmitted and died after discharge in the preceding 30 days have been identified. These cases will be examined to review escalation planning and discharge suitability.

Further work to examine the community element of this pathway is ongoing.

Analysis is being sought from the Microbiology department of this winters' respiratory pathogens to see if this accounts for the rise in mortality.
Estimated completion July 2020
Update Nov 2020:
This has been considered a COVID-19 effect likely evident prior to the availability of testing. Action closed.

Analysis of AKI deaths is progressing with two cohorts – AKI on arrival and AKI as an inpatient.
Estimated completion August 2020
Update Nov 2020:
Action modified to examine AKI and fluid and electrolyte disorders as described above. Review of AKI on admission found this was often due to severe underlying co-morbidity and often resolved, while severe co-mobility remained terminal.

New completion date: January 2021

Examine and define the output from a departmental mortality meeting.
Estimated completion October 2020
Update Nov 2020:
Slideset developed by Dr Masroor Diwan and Dr Patrick McDonald in use in medicine, has been shared with other departments as a template. Anaesthetics/ICU has used with success. Requires input from Integrated Governance Department to create standardised report.

New completion date Feb 2021

Devise a system for reporting themes from the subjective data in completed SJR reviews, both upwards and to the shop floor.
Estimated completion August 2020
Update Nov 2020:
Joint M&M with Anaesthetics and Orthopaedics to focus on SJR thematic analysis. Results to inform next steps.

New Completion Date: Jan 2021

5. Standing Recommendations

Ensure proactive monitoring of capacity and demand within the system occurs; those performing this monitoring must be clear that decisions taken to manage surges in demand

have real consequence on patient mortality. Include measures to increase clinical capacity and measure to reduce demand.

Continue to evaluate and invest in activity which provides capacity to manage serious illness quickly and aggressively to reduce complications and length of stay.

Encourage and support interventions which support staff to work reliably and consistently, with minimal variation, such as through the adoption of appropriate IT or best practice pathways which are clear and available.

Support ward processes and ward care with the same intention as supporting AED in order to improve the quality of patient care and thereby improve flow and improve safety. Start by engaging with ward teams such as junior medical staff and junior nurses to understand the issues they face.

APPENDIX 1

Southport & Ormskirk SHMI Analysis September 2020

By Michael Lightfoot – Head of Information

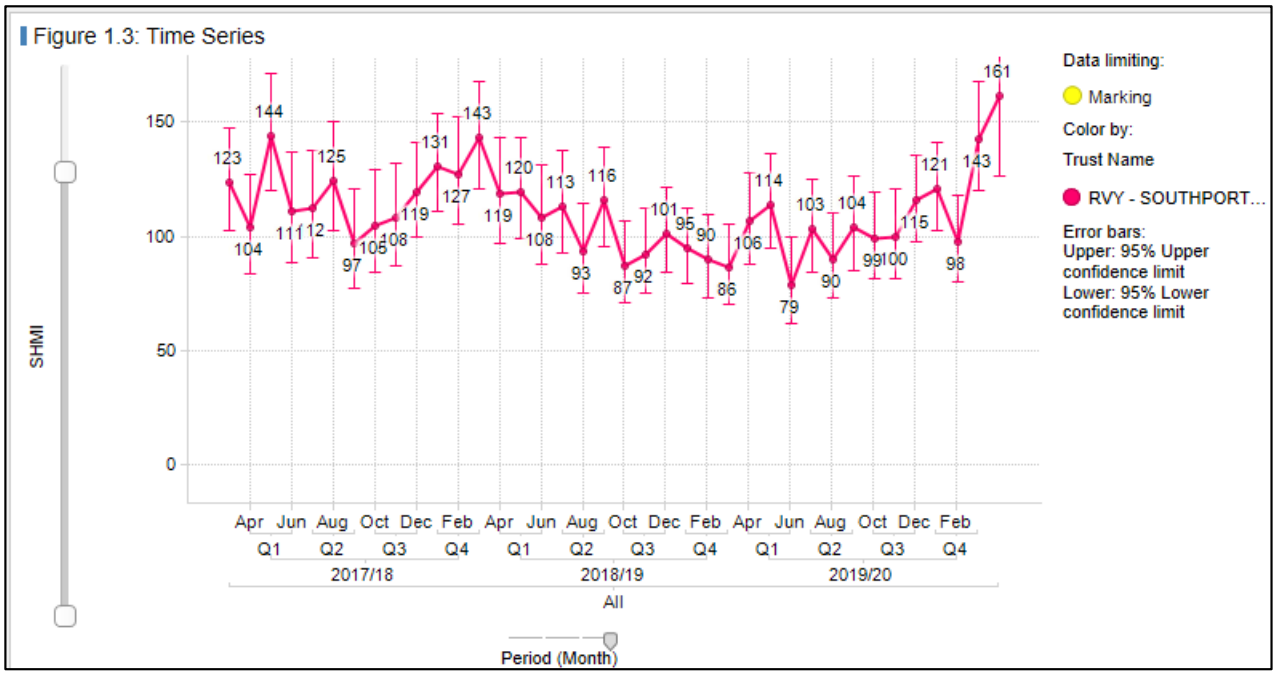
1. Background

1.1. The latest Trust SHMI, released in August 2020 for the 12-month period ending March 2020 is 103. HED data, which is a predictor for the next release, is predicting a further increase to 109 for the 12-month period ending April 2020. This is also suggesting an in-month SHMI value of 161 for April alone.

1.2. Due to the impact of Covid the regulators have stipulated that any spells with a Covid diagnosis are to be removed from mortality statistics – having a large effect on both the number of expected and actual deaths.

2. SHMI Overview

2.1. If we look at the monthly SHMI in time series (not rolling 12 month) we can see that March 2020 was the highest since March 2018, with April 2020 the highest on record. The last 2 months are the primary cause for the recent increase in the rolling 12-month value.



2.2. In April 2020, with Covid patients excluded, the Trust has 72 deaths (in hospital or within 30 days of discharge) but this is against 42.62 expected deaths. If we compare this to April 2019 the Trust had 117 deaths against an expected number of 109.94.

2.3. The adjustment for Covid this year has reduced the Trusts expected deaths by 59% but the actual number of deaths has only decreased by 38%.

2.4. This disparity has caused the sharp increase in the monthly SHMI.

3. April 2020 SHMI

3.1. The top 10 Diagnostic Groups measured by relative SHMI are shown below.

Diagnostic Group	SHMI	Actual Deaths	Expected Deaths
41 :: Coagulation and hemorrhagic disorders, Immunity disorders, Other hematologic conditions, Sickle cell anemia	6286.88	2	0.03
139 :: Malaise and fatigue	1821.49	1	0.05
50 :: Epilepsy; convulsions	1176.71	1	0.08
35 :: Diabetes mellitus with complications	1149.8	1	0.09
71 :: Other circulatory disease	1080.7	2	0.19
128 :: Complication of device; implant or graft	749.41	1	0.13
90 :: Anal and rectal conditions, Diverticulosis and diverticulitis	733.07	1	0.14
46 :: Encephalitis (except that caused by tuberculosis or sexually transmitted disease), Meningitis (except that caused by tuberculosis or sexually transmitted disease), Other CNS infection and poliomyelitis	580.92	1	0.17
120 :: Fracture of neck of femur (hip)	559.25	4	0.72
129 :: Complications of surgical procedures or medical care	556.55	1	0.18
		15	**1.78**

3.2. These 10 diagnostic groups only account for 15 (20.8%) of deaths this month

3.3. If we look at the top 10 Diagnostic Groups measured by actual number of deaths, we get a different perspective;

Diagnostic Group	SHMI	Actual Deaths	Expected Deaths
73 :: Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	161.5	12	7.43
2 :: Septicemia (except in labor), Shock	170.02	8	4.71
66 :: Acute cerebrovascular disease	132.58	5	3.77
120 :: Fracture of neck of femur (hip)	559.25	4	0.72
65 :: Congestive heart failure; nonhypertensive	149.08	3	2.01
77 :: Aspiration pneumonitis; food/vomitus	132.88	3	2.26
41 :: Coagulation and hemorrhagic disorders, Immunity disorders, Other hematologic conditions, Sickle cell anemia	6286.88	2	0.03
71 :: Other circulatory disease	1080.7	2	0.19
98 :: Other gastrointestinal disorders	403.91	2	0.5
75 :: Chronic obstructive pulmonary disease and bronchiectasis	359.75	2	0.56
		43	22.18

3.4. These 10 diagnostic groups account for 60% of deaths in this month.

3.5. The most common cause of death this month was Pneumonia with 12 against an expected value of 7.43, giving a SHMI of 161.5.

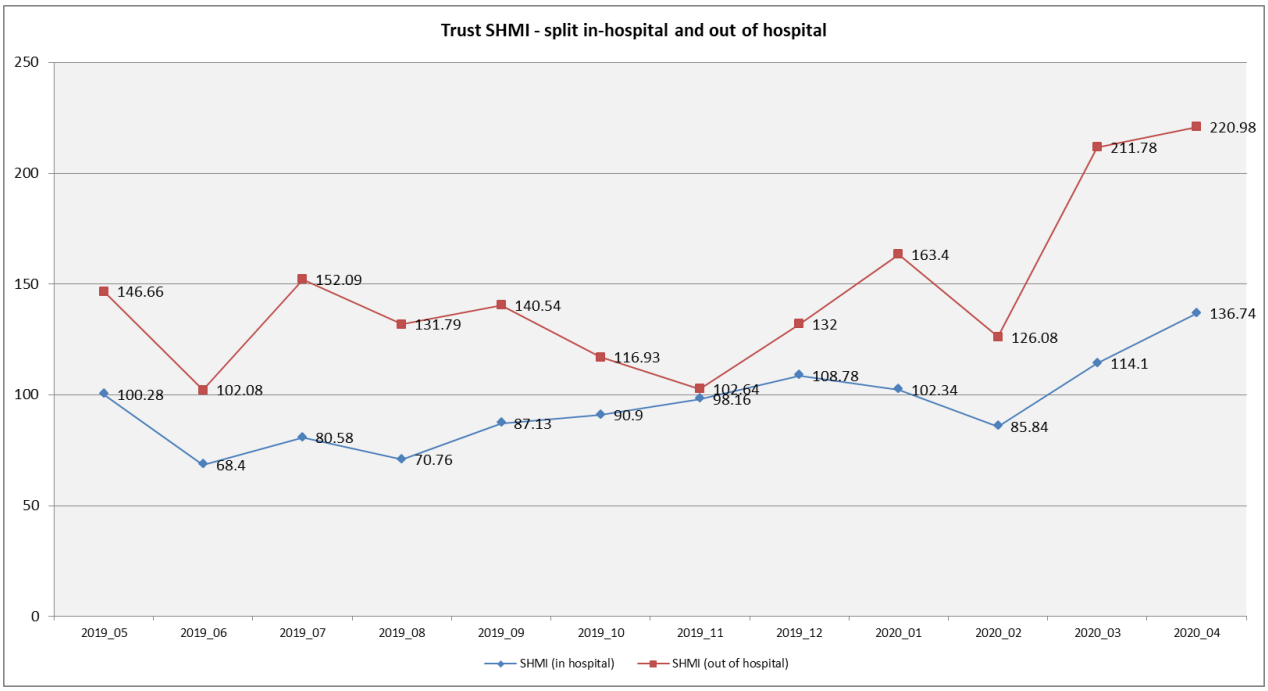
3.6. In comparison for April 2019 for Pneumonia there were 23 deaths against an expectation of 14.09 with a SHMI of 163.

3.7. This shows that in those areas with the highest numbers of actual deaths there has been no real change between last year and this year.

3.8. The increase in SHMI is being driven by changes in those diagnostic groups which have very small numbers of expected deaths (less than 1) and there being a single case. (e.g. Coagulation and haemorrhagic disorders, Immunity disorders, Other hematologic conditions, Sickle cell anaemia – expected 0.03 deaths and we had 2 giving a relative SHMI of 6286.88). Put into context this is the equivalent of having an actual death rate of 33 when only 1 is expected.

4. In-hospital deaths vs deaths within 30 days of discharge

4.1. The following chart shows the relative SHMI values for each month split by deaths in hospital and within 30 days of discharge. There is a clear disparity between the two in the most recent 2 months, with the out-of-hospital SHMI increasing by 75% and the in-hospital increasing by 59%.



5. Conclusion

5.1. The Trust has seen a recent increase in its SHMI, with April 2020 showing a sharper rise than previous trend. There are likely multiple reasons for this. Primarily the removal of Covid diagnoses from Trust discharges has affected both the expected and observed number of deaths.

5.2. For smaller Trusts, where numbers have been artificially lowered, the relative gap between observed and expected deaths becomes more significant in determining the SHMI. Even 1 death can have a large effect in some diagnosis groups.

5.3. The recent rise in Trust SHMI is also a result of a disproportionate rise in the out-of-hospital SHMI compared to the in-hospital SHMI as seen in the chart above.

5.4. During the early stages of Covid there was a concerted effort to increase discharge rates, this could have caused a disproportionate increase in out of hospital deaths from patients who may have probably died in hospital if they would have remained as inpatients.

5.5. Our own data already shows that May 2020 had a drastically reduced number of hospital deaths, I would expect the next month's SHMI to show a sharp decrease in the in-hospital SHMI as there is a cohort of patients who should have been hospital deaths this month who have been counted in the previous months deaths-within-30-days-of-discharge numbers.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB198/20**	**FOI Exempt**	**NO**
Report Title	**MEDICAL VACANCIES UPDATE**		
Executive Lead	Dr Hankin, Executive Medical Director		
Lead Officer	Dr Hankin, Executive Medical Director		
Action Required	☐ **To Approve** ☐ **To Assure**	✓**To Note** ☐ **To Receive**	

Purpose

To inform the Trust Board of our current position on Medical Vacancies and the challenges going forward. The report provides a snapshot for November 2020.

Executive Summary

This paper outlines the current vacancies in the medical workforce in relation to establishment.
In comparison with May 2020 it is an improving position.
The impact of the recruitment crisis is felt most acutely in Medicine and Anaesthesia.
The RCP census findings (appendix 1) illuminate the crisis in the 'medical' workforce.

Recommendations

Expansion of non-medical practitioner base, rationalisation/transformation of services, partnerships with neighbouring Trust's is the way forward.

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:**
Dr Hankin, Executive Medical Director	Dr Hankin, Executive Medical Director

Southport and Ormskirk Hospital NHS Trust

SOUTHPORT & ORMSKIRK MEDICAL VACANCIES

November 2020 SNAPSHOT

INTRODUCTION

This Board paper outlines the current vacancies in the medical workforce in relation to establishment. In comparison with May 2020 it is an improving position.

Medical Workforce Position (*November 2020*)

*The Changes from May 2020 are in **red**.*

	VACANCIES	LOCUMS	ESTABLISHMENT
Anaesthesia			
Consultants	3 5	1	19.43
SAS	5 11	2	18
Orthopaedics			
Consultants	0	0	10
SAS	4	3	10
Surgery			
Consultants	0	0	7
SAS	4	3	9
Urology			
Consultants	0	0	2.5
SAS	0	0	5
Radiology			
Consultants	3	2.2	6.2
SAS			
Paediatrics			
Consultants	0	1	11.6
SAS	0 1	0	6 9
Emergency Medicine			
Consultants	0	1	10
SAS	0	0	6.6
Obstetrics & Gynaecology	1.95 1	0	12.7
Consultants	0	0	2
SAS			
Medicine			
Consultants	13.75 18.4	9	30.15
SAS	5.2 6	6	21.8

Dr T Hankin
Executive Medical Director
November 2020

Appendix 1

From the RCP census document dated 30th October 2020

Key findings-

2020 has been dominated by the profound effects on the UK NHS of the COVID-19 pandemic. Although the census covers the pre-COVID period, as the NHS moves from crisis management to recovery, longer term issues will need to be addressed. The 2019 census reveals the continuing pressures on the medical workforce and the systems in which we work, prior to the pandemic.

The number of consultant posts needed continues to significantly outnumber supply.

Close to half (43%) of advertised consultant posts in England and Wales were unfilled due to a lack of suitable applicants (data for Scotland and Northern Ireland were unavailable).

The ratio of consultant physicians to population served varies widely. Regions with fewer consultants have the highest rates of locum consultants, and, for England and Wales, unfilled advertised posts.

Consultants find their general internal medicine (GIM) work much less satisfying than specialty work.
Unselected medical take/receiving was undertaken by only 30% of consultants and care of GIM inpatients by 42% of consultants.

20% of consultants experienced, and 25% witnessed, bullying or harassment. This was more common among female consultants.

Consultants of black, Asian and minority ethnic origin (BAME) were twice as likely to experience discrimination as white consultants. Female consultants were twice as likely to experience discrimination as male consultants.

Consultants estimate they work 10% more than they are contracted to do, mainly due to their clinical workload.

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB198/20**	**FOI Exempt**	**NO**
Report Title	**MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT (2019-20)**		
Executive Lead	Dr Terry Hankin - Executive Medical Director /Responsible Officer		
Lead Officer	Mr Kevin Thomas - Deputy Medical Director/Clinical Medical Appraisal Lead		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

The purpose of this paper is to assure the Board that appropriate processes are in place to ensure that the Trust is compliant with its legal obligations as per '***The Medical Profession (Responsible Officers) Regulations 2010' (amended 2013)*** and continues to provide a robust medical appraisal and revalidation system.

All responsible officers have been requested to present an annual report to their Board, using '***The Framework of Quality Assurance for Responsible Officers and Revalidation'*** (FQA) template and submit a ***'Statement of Compliance'*** to the Higher Level Responsible Officer at NHS England.

Executive Summary

As at the end of the appraisal cycle on 31st March 2020, the Trust was the 'designated body' for 199 doctors. 83.5% of doctors completed a medical appraisal in the required timescales in line with GMC requirements. The reasons for late, incomplete or missed appraisals are as below:

	2018/19	2019/20
Appraisals completed on time (i.e. before 31.3.20)	183 (92.90%)	166 (83.5%)
Approved missed or late appraisals - sickness/maternity - clinical commitments/other	6 (3.05%) 6 (3.05%)	5 (2.5%)
Approved late appraisals completed - (COVID)	N/a	24 (12%)
Approved missed appraisal not completed - (COVID)	N/a	4 (2%)
Unapproved missed or late appraisal (i.e. not authorised by RO)	2 (1.00%)	0(0%)
TOTAL	197	199

Recommendations

The Board is asked to approve the contents of the report and sign off the ***'Statement of Compliance'*** for forwarding to NHSE.

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:**
Ann Higgin - Appraisal & Revalidation Manager	Dr Hankin – EMD/Responsible Officer

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of **SOUTHPORT AND ORMSKIRK NHS TRUST** can confirm that:

1. **The Annual Organisational Audit (AOA) for this year has been submitted.**

Date of AOA submission: **20.10.20**

Action from last year: Continue with supportive and structured appraisal process and continue to improve % completion rate where possible.

Comment: Despite the challenges at the start of the COVID pandemic earlier this year, the Trust achieved an overall medical appraisal completion rate of 95.5% for the year albeit that 12% were completed late (i.e. after 31.3.20).

The GMC/NHSE advised in March that medical appraisals could be suspended if necessary but left it to Responsible Officers locally to determine what action to take. Doctors with an outstanding appraisal were given the option to request an *'approved missed appraisal'* due to the COVID pandemic, however only 5 doctors chose to do so.

Action for next year: Medical appraisal was formally restarted in October with the focus being on doctor's health, wellbeing and development and minimising the administrative burden involved in appraisal. We need to continue to review and improve the process with the same aim.

2019/20	**No.**	**%**
Appraisals completed on time in accordance with category 1 of NHSE Annual Organisation Audit AOA (i.e before 31.03.20)	166	83.5%
Appraisals completed after 31.03.20	24	12%
Approved missed or late appraisals - (sickness/maternity)	5	2.5%
Approved missed appraisals due to Covid pressures	4	2%
TOTAL	199	100%

2. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Action from last year: N/A

Comments: Dr Terry Hankin was appointed the Responsible Officer (RO) for the Trust on 07.01.2019. Dr Hankin has undertaken the required RO training programme and has an annual appraisal undertaken by an external appraiser appointed by NHSE.

Action for next year: N/A

3. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Yes

Action from last year: N/A

Comments: - the RO is supported by the Clinical Appraisal Lead (Mr Kevin Thomas) and the Appraisal and Revalidation Manager (Ann Higgin).

Action for next year: N/A

4. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

Action from last year: N/A

Comments: Reports received from HR are cross referenced with the 'GMC Connect' system by the Appraisal and Revalidation Manager on a monthly basis to maintain an accurate record.

Action for next year: Continue process

5. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from last year: N/A

Comments: The Appraisal and Revalidation Policy is currently being updated.

Action for next year: Review Policy and publish on intranet.

6. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from last year: N/A

Comments: A review was undertaken by Mersey Internal Audit in 2014 and a Higher Level Responsible Officer Quality Review with representatives from NHSE in November 2016. Feedback from both was positive.

Action for next year: Consider any other appropriate reviews

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: N/A

Comments: All doctors holding a contract of employment are supported by the Trust and given the resources to undertake an annual appraisal regardless of whether they are employed as a locum or permanent doctor. The Risk Department provide information in relation to complaints, claims, incidents suis etc. for all doctors(whether or not from a different prescribed connection) to enable reflection.

Action for next year: Continue to support doctors.

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

Action from last year: N/A

Comments: All doctors are required to complete relevant declaration forms concerning participation in any outside work and include supporting information for their full scope of work in their appraisal.

Information relating to complaints, claims, suis, and incidents is made available to all doctors to allow reflection. Where applicable clinical benchmarking data is also provided.

Action for next year: Continue process

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Action from last year: N/A

Comments: N/A

Action for next year: N/A

3. **There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

Action from last year: N/A

Comments: MED STAFF 14 Medical Appraisal and Revalidation Policy is in place. The policy is currently being updated.

Action for next year: Review and update as necessary

4. **The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

Action from last year: N/A

Comments: There are currently 39 appraisers (30 Consultants and 9 SAS/AS doctors).

Action for next year: Continue to review and train additional appraisers as necessary.

5. **Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).**

Action from last year: N/A

Comments: Appraiser Support Groups are usually held at least once a year to discuss topical issues, challenges and share best practice in a confidential environment.

Following completion of their appraisal, doctors are requested to complete an appraisal feedback form. This information is anonymised and a summary report collated for each appraiser for them to include and reflect upon in their appraisal. Any concerns highlighted are discussed with the RO and the doctor and any relevant action taken (e.g. retraining).

Action for next year: Continue

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from last year: N/A

Comments: Internal quality assurance measures including review of portfolios are in place.

An Annual Board Report and Statement of Compliance are shared with the Board. Appraisal completion rates are published monthly.

Action for next year: Continue

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from last year: N/A

Comments: All recommendations made to the GMC to date have been considered and submitted on time.

Appraisal portfolios are reviewed for all doctors by the Appraisal & Revalidation Manager, Clinical Lead and/or RO before making a revalidation recommendation to the GMC to provide assurance that the outputs, declarations and supporting information provided meet the necessary requirements.

Due to the Covid pandemic the GMC postponed a number of doctors revalidation dates for 12-18 months in order to allow doctors more time to collect the relevant supporting information and Responsible Officers more time to consider the doctors portfolios.

Action for next year: Continue process

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: N/A

Comments: Doctors are made aware of all revalidation recommendations prior to submission to the GMC. Any deferrals are discussed with the doctor and a plan of action agreed, documented and monitored.

Action for next year: Continue process

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: N/A

Comments: There are clear effective systems in place for reporting and reviewing significant events, complaints and clinical performance. Openness and reporting of incidents is encouraged.

Action for next year: Continue

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: N/A

Comments:

Doctors who have been involved in any complaints, claims, never events etc. are required to include a reflection of the incident in their annual appraisal portfolio. This information is provided to the Appraisal and Revalidation Manager by the Risk department and is uploaded into the doctor's appraisal portfolio prior to appraisal. Doctors also undertake a 360 patient and colleague feedback exercise at least once in each revalidation cycle.(Although currently formal patient feedback is difficult to obtain given the COVID pandemic and it no longer being practical to ask patients to use paper or electronic devices on site due to infection control).

Clinical benchmarking data is also provided where appropriate. The Trust has recently changed the system for obtaining clinical benchmarking data from Dr Foster to HED (Health Evaluation Data) created by University Hospitals Birmingham which is used by NHS hospitals across England. Training is currently being undertaken on the interpretation and downloading of the data.

Action for next year: Ensure doctors aware of how to access and interpret data.

3. **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year: N/A

Comments: The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS" (MHPS) is followed.

The RO, Deputy Medical Director and HR Director meet on a monthly basis to discuss any issues.

The RO attends a serious incident report group on a regular basis to monitor overall response to serious incidents in the organisation

Quarterly meetings are held between the RO and the GMC's employment Liaison Advisor to discuss any performance or revalidation issues.

Action for next year: Continue to follow process

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].**

Action from last year: N/A

Comments: The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/Senior Medical Management in the organisation as per policy.

The RO is satisfied with the quality of management of concerns in the organisation

Action for next year: Continue

5. **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].**

Action from last year: N/A

Comments: Relevant RO to RO references are issued. Any immediate concerns are raised by the RO with any other relevant RO in a timely and appropriate manner.

Action for next year: Continue

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).**

Action from last year: N/A **Comments**: The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS" (MHPS) and other relevant Trust policy are followed. **Action for next year:** Continue

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from last year: N/A **Comments:** The Trust has an appropriate procedure in place operated by the medical staffing department, for obtaining relevant information when entering into a contract of employment with doctors for the provision of services **Action for next year:** Continue

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year's actions:

In anticipation of the role of Physician Associates being regulated in the near future, we have started to include these in the medical appraisal process using a revised template.

Actions still outstanding:

No actions outstanding

Current Issues:

No current issues

New Actions:

Appraisal and Revalidation Policy review.

Overall conclusion:

Engagement in medical appraisal continues to be very positive considering the clinical challenges this year.

Additional Note: QUEENSCOURT HOSPICE

Although Queenscourt Hospice is now a designated body in its own right the Trust continues to provide a responsible officer for the hospice given the small number of doctors employed (3). The hospice is provided with a separate board report and AOA and the Trust provides appraisal support for the hospice under a formal SLA. Two doctors at Queenscourt have been trained as appraisers and act as appraisers for the Trust.

Section 7 – Statement of Compliance:

The Board of **SOUTHPORT AND ORMSKIKR NHS TRUST** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman

Official name of designated body: **SOUTHPORT AND ORMSKIRK NHS TRUST**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	23 NOVEMBER 2020
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- There remains a substantial funding gap in the North West region in months 7 – 12 of this financial year. As such, the Trust is still awaiting confirmation of our funding allocation for this period. The position will be reassessed in December, and will account for expenditure patterns across October and November.
- There remains a risk concerning the deliverability of out-of-hospital care within the system.

ADVISE

- The committee have recommended that the IM&T work plan requires a review and update, to ensure effective prioritisation of work to deliver the strategy. It was recommended that this should consider potential adjustments to the current oversight and governance arrangements that are place for IM&T.
- The committee received the welcome news that the Trust is optimistic at being able to appoint a Chief Clinical Information Officer shortly.
- The committee received an early draft of the 5 year capital plan, which highlighted a funding gap in 2021-22 of c£2.5m. Further work will now be undertaken to explore additional sources of income, provide confirmation of the capital costs, and to prioritise projects. The committee has requested greater assurance that decisions concerning the capital plan will be aligned with the strategic direction and corporate priorities of the Trust, more generally.
- The committee were provided with a useful breakdown of occupancy and utilisation trends at Ormskirk District General Hospital, which will aid more accurate future reporting and help to inform options for achieving better utilisation performance going forward.
- The committee were pleased to acknowledge the efforts of staff to restore elective activity close to pre-COVID levels, whilst still maintaining urgent care provision. Despite a consistently challenging environment, the Trust's elective restoration performance is second highest within the region, and the Trust have been able to maintain a zero tolerance policy towards corridor care.
- At the request of the committee, a report was received to advise upon the execution of the PWC recommendations concerning Clinical Nurse Specialists. Whilst some progress has been made, particularly in regards to the review of job descriptions and job plans, there has been little progress made towards realising the substantial CIP opportunities that PWC identified. Further work is still needed to identify and deliver where efficiencies can be achieved.
- The Trust's month 7 financial performance delivered an underspend against the provisional budget allocation that was agreed with the regulator. Meeting planned expenditure across month 8 - 12 will be effected by the Trusts ability to recruit the planned additional staffing required to support the COVID response.
- The Committee has requested a progress report in relation to the utilisation and roll out of PLICs and model hospital data.

ASSURE

- It was reported to the committee that the Venn Demand & Capacity modelling has provided external assurance in regards to the potential effectiveness of the system

winter plan. If partners deliver all the schemes in full then the modelling concludes that the Trust should achieve an occupancy level of under 80%.
New Risks identified at the meeting: None
Review of the Risk Register: *No action taken*

Southport and Ormskirk Hospital NHS Trust

Operations

Access

Analyst narrative:

Although the 4 hour A&E compliance and the Ambulance Handovers are the only indicators which are failing to provide assurance, the 90% stay on Stroke Ward requires corrective action, with negative variation caused by a significant deterioration in performance in October, impacted by Covid-19 and ward closures. An MIAA audit has been commissioned to review processes around data validation in relation to this indicator.
There are a number of indicators relating to RTT which are showing negative variation as a result of Covid-19. Whilst there has been an improvement in October, it may be difficult to maintain this improvement throughout the winter period and it is expected that these will continue to deteriorate until next year before returning to expected levels. Diagnostic waits continues to show negative variation due to the continued impact of Covid-19.

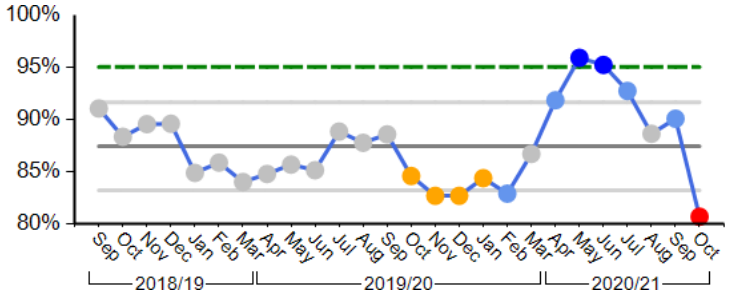
Operational narrative:

Ambulance Handovers

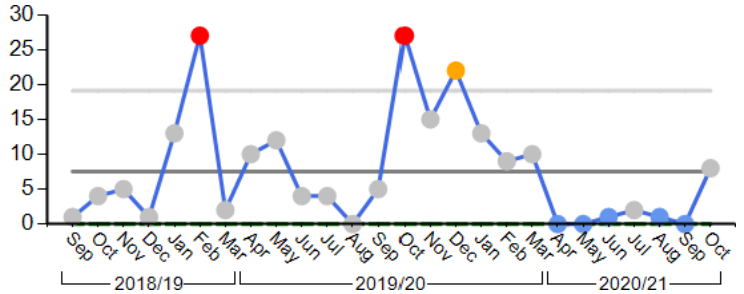
The trust has been under sustained pressure since late September due to the 2nd wave of Covid-19; on the 14th October the North West was placed in Tier 3 lockdown ahead of the national lockdown on 5th November. The Southport site has suffered multiple Covid-19 outbreaks resulting in bed closures and ward closures, this has severely hampered flow through the hospital. Despite deterioration in handover performance the ED has maintained its excellent performance on 0% corridor care.
See also Stroke/TIA action plan.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	80.7%	1526	Oct 20		95%	90.1%	Sep 20	95%	90.4%	F
Accident & Emergency - 12+ Hour trolley waits	0	8	8	Oct 20	L	0	0	Sep 20	0	12	?
Ambulance Handover 30-60 Mins	0	74	74	Oct 20	L	0	20	Sep 20	0	189	F
Ambulance Handover Over 60 Mins	0	13	13	Oct 20	L	0	2	Sep 20	0	34	?
Referral to treatment: on-going	92%	81.1%	1529	Oct 20	L	92%	75.2%	Sep 20	92%	71.5%	?
52 Week Waits	0	35	35	Oct 20	H	0	53	Sep 20	0	35	?
Diagnostic waits	1%	17.4%	514	Oct 20	H	1%	16.5%	Sep 20	1%	33%	?
Stroke - 90% Stay on Stroke Ward	80%	27.8%	13	Oct 20	L	80%	89.3%	Sep 20	80%	72.4%	?
TIA	60%	60%	2	Sep 20		60%	100%	Aug 20	60%	57.9%	?
Cancelled Operations	0.6%	0.1%	2	Oct 20		0.6%	0.4%	Sep 20	0.6%	0.2%	?
Total RTT Waiting List - Trust		8107	8107	Oct 20	L		7797	Sep 20		8107	?
Total RTT waiters > 30 Weeks - Trust		987	987	Oct 20	H		1124	Sep 20		987	?
Total RTT waiters > 42 Weeks - Trust		219	219	Oct 20	H		240	Sep 20		219	?

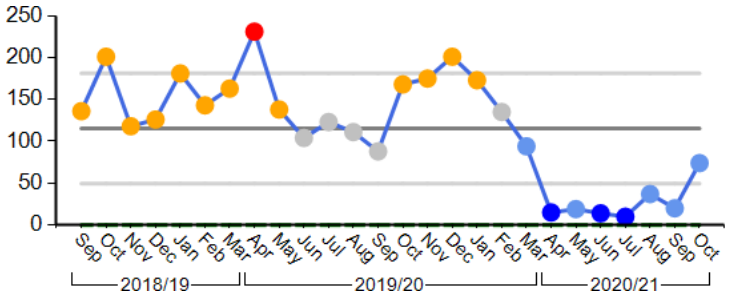
Accident & Emergency - 4 Hour compliance



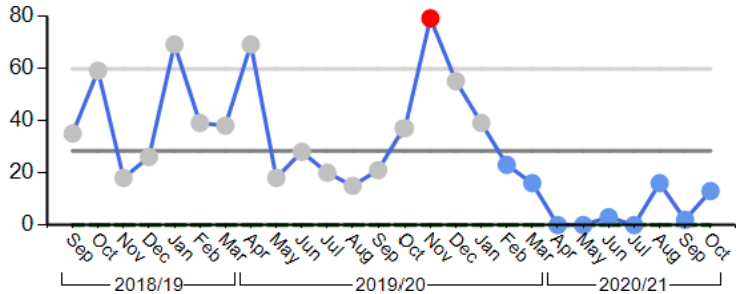
Accident & Emergency - 12+ Hour trolley waits



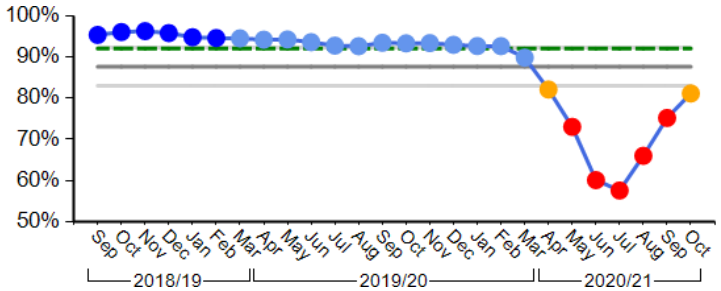
Ambulance Handover 30-60 Mins



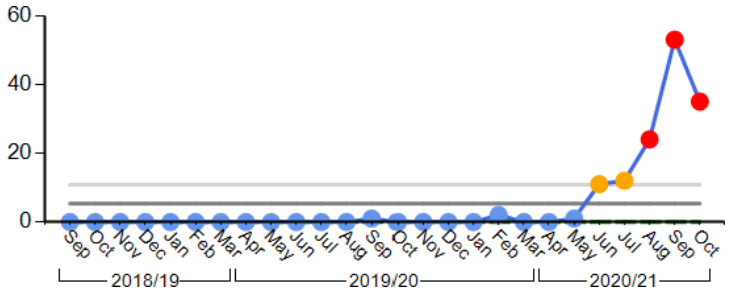
Ambulance Handover Over 60 Mins



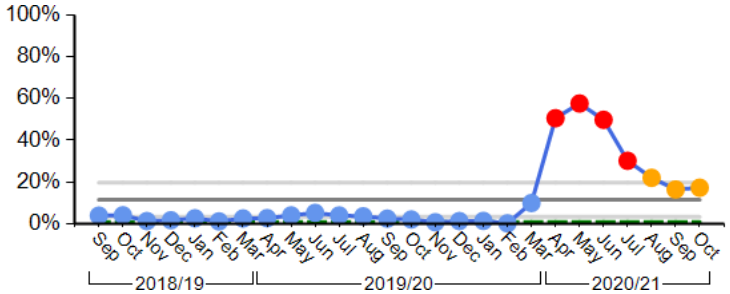
Referral to treatment: on-going



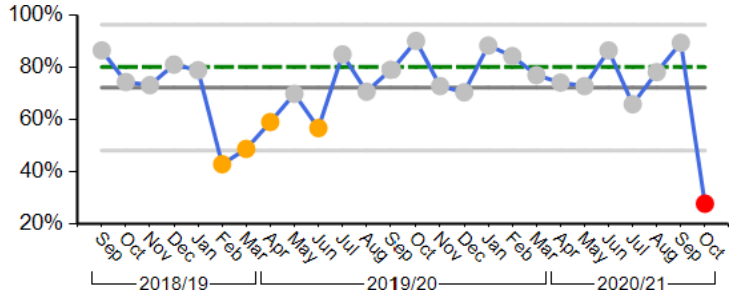
52 Week Waits



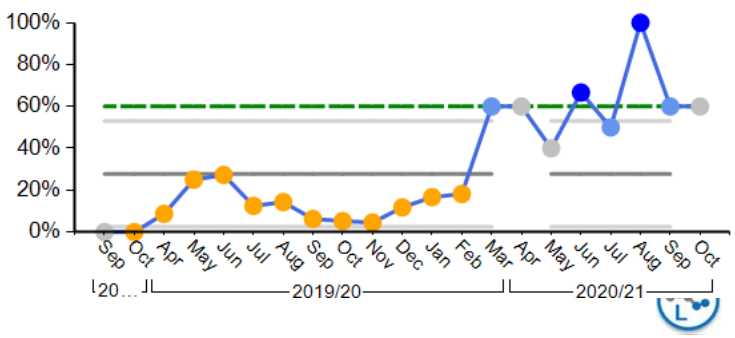
Diagnostic waits



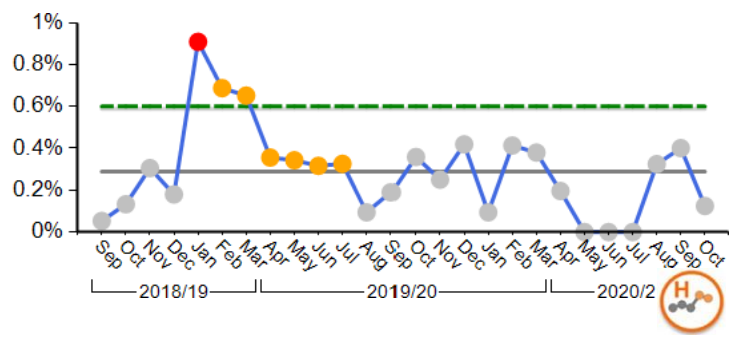
Stroke - 90% Stay on Stroke Ward



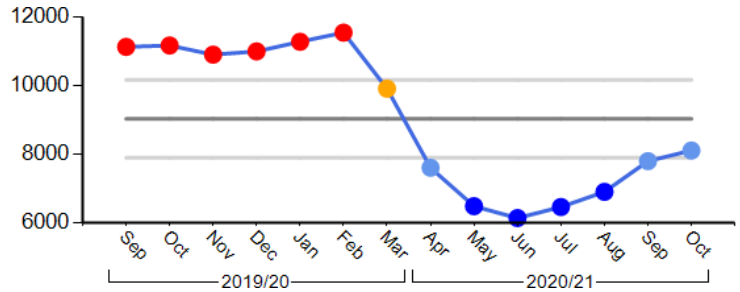
TIA



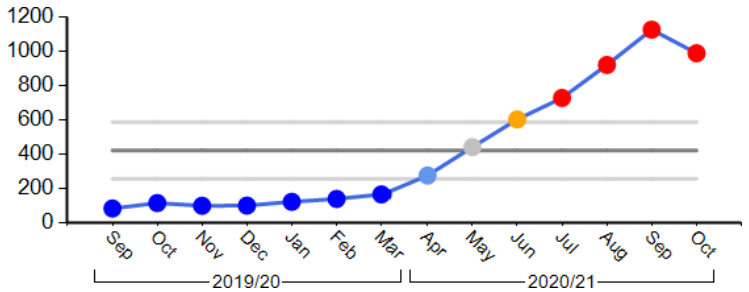
Cancelled Operations

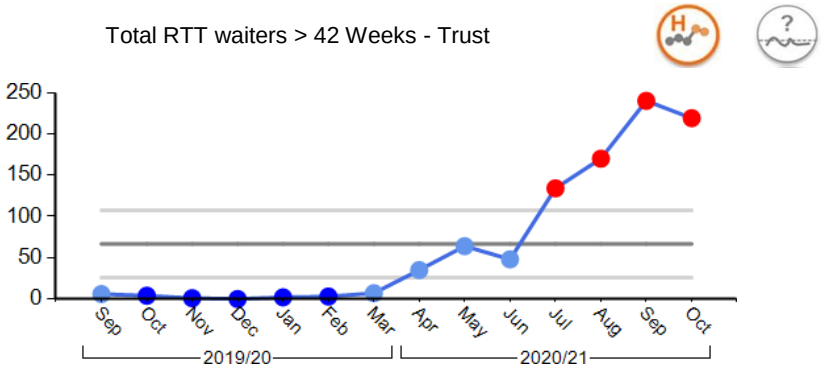


Total RTT Waiting List - Trust



Total RTT waiters > 30 Weeks - Trust

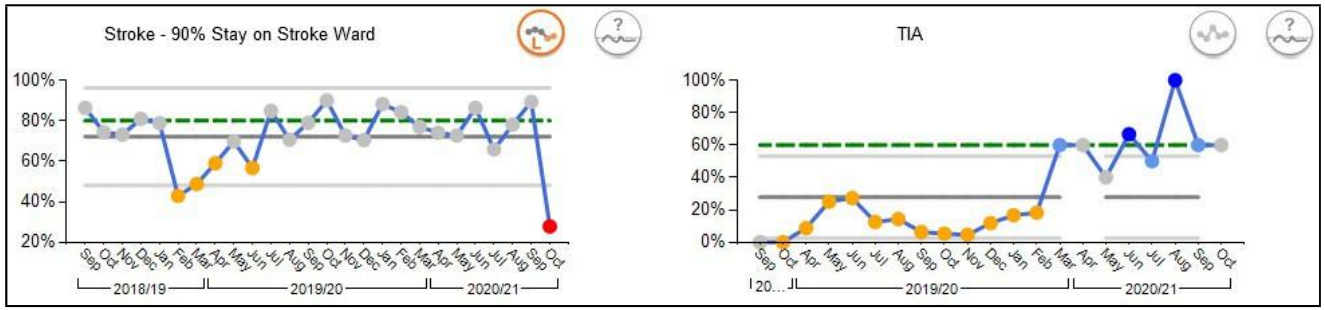



Total RTT waiters > 42 Weeks - Trust
250
200
150
100
50
0
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
2019/20
2020/21

TIA & Stroke

Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Stroke - 90% Stay on Stroke Ward	80%	27.8%	13	Oct 20		80%	89.3%	Sep 20	80%	72.4%	
TIA	60%	60%	2	Sep 20		60%	100%	Aug 20	60%	57.9%	



Background: Proportion of patients diagnosed with a TIATreatedwithin24hours.Threshold60%.

Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%.

Situation: for TIA although recent variation is positive a lack of consistent positive performance means there is no confirmed assurance for this key measure.

TIA Performance for October there was no relevant patients for this indicator, data is from September.

Issues:

- Impact of Covid-19: Loss of dedicated Stroke Ward due to Covid-19 during October (all of the patients who breached were due to patients not being admitted to Acute Stroke Ward due toward closure. Ward re-opened 04.11.20.
- Impact of Covid-19: - Any Covid-19 positive patients would be admitted to 15a/15b and then transferred to 7b on recovery for rehabilitation

Actions:

- Revised SOP now in place which includes:
  - Weekly clinical validation of breaches
  - Revision of inclusion/exclusion criteria
  - Monthly sign off at CBU weekly performance meetings
- Addition of an alert to Medway to highlight Stroke admissions to improve oversight
- Work underway with MIAA to review the systems and processes in place for reporting Stroke data.

Mitigations :

- Impact of Covid-19: Stroke ward re-opened to admissions on4thNovember.
- Continue to monitor Covid-19 positive patients through bed meeting and transfer any patients from Stroke ward at earliest opportunity.
- Surge Plan to be reviewed at earliest opportunity if Covid-19 positive patients remain on ward.

Operations

Cancer

Analyst narrative:

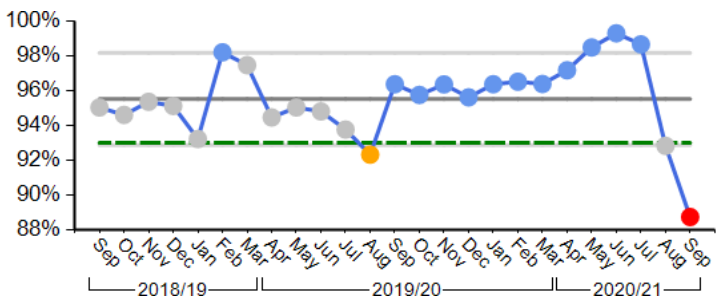
Despite recent positive variation, the 14 day GP referral to Outpatients has decreased significantly in September with the compliance outside the 2nd lower control limit. This is a cause for concern which requires action to address. The 62 day indicator is showing no significant variation but is not consistently passing the target; therefore further narrative/action is required.

Operational narrative:

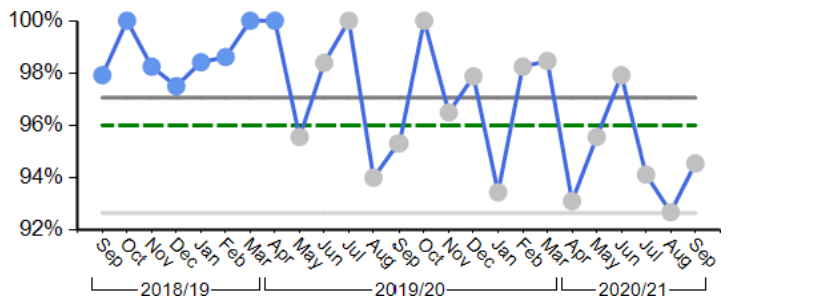
See supplementary action plan.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	88.7%	106	Sep 20		93%	92.8%	Aug 20	93%	95.2%	
31 day treatment	96%	94.5%	3	Sep 20		96%	92.7%	Aug 20	96%	94.6%	
62 day GP referral to treatment	85%	73.1%	12.5	Sep 20		85%	79.6%	Aug 20	85%	78.8%	

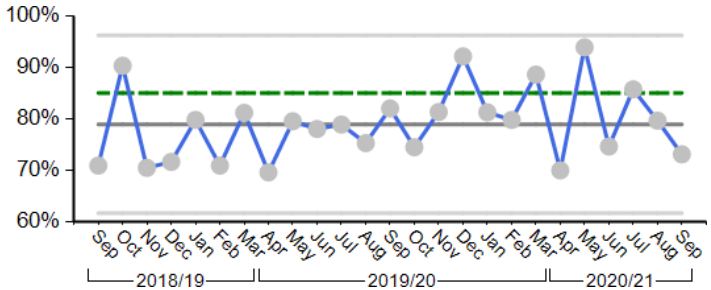
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment



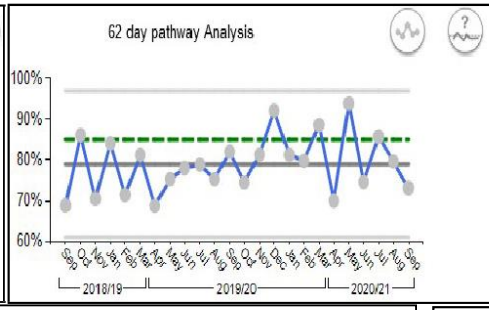
Cancer Measures

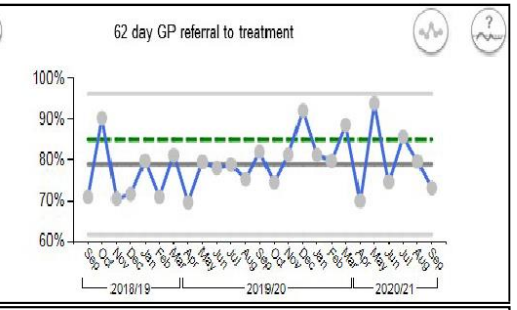
Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
14 day GP referral to Outpatients	93%	88.7%	106	Sep 20	H	93%	92.8%	Aug 20	93%	95.2%	?
31 day treatment	96%	94.5%	3	Sep 20		96%	92.7%	Aug 20	96%	94.6%	?
62 day pathway Analysis	85%	73.1%	12.5	Sep 20		85%	79.6%	Aug 20	85%	78.8%	?
62 day GP referral to treatment	85%	73.1%	12.5	Sep 20		85%	79.6%	Aug 20	85%	78.8%	?

Situation:

- 14 Day cancer performance has shown further deterioration in September.
- 31 day treatment is showing no significant variation with an improving figure in September
- Both 62 day measures are not assured and are not showing signs of improvement.





Issues:

- Although the Trust was not compliant for any of the national standards we achieved against the 62 day 0.5% recovery trajectory and 104 day trajectory. A significant number of our pathways are reliant on other providers to ensure compliance.
- 14 day target – failure of this target continues to be primarily due to issues in the endoscopy department around capacity and staffing; it is not expected that this indicator will achieve plan in October and November.
- 31 day target – 3 x skin, 1 cancelled due to the Doctor self- isolating, 1 due to unavailability of swab results and 1 patient unwell on the day, rebooked but outside 31 days.
- 62 day RCAs completed for all 12.5 breaching patients. Similar issues to previous month identified. Patients self isolating and swabbing delays, & theatre capacity. Scan are not always requested as a target priority.

Actions:

- The move of MDU out of the Treatment Centre has resulted in reinstated activity in the endoscopy department, with a gradual staggered resumption of activity. This started mid-October so should start to have an impact on waiting times from the end of November which should be reflected in a better position for the two week wait target in December.
- Covid-19 restrictions are still impacting on capacity in theatres and for minor ops. Use of the cancer hub at Whiston is being actively encouraged and patients being identified for transfer.
- Clinical teams to be reminded of the importance of correctly prioritising scan requests.
- Additional Two week wait information to be reviewed weekly in cancer performance meeting
- SOP for review of long waiters to be produced SOP to be written around the process for swabbing prior to procedures.

Mitigations

- Continue to protect cancer surgery at all times. Weekly monitoring of endoscopy waiting times.
- Weekly review of surgical waiting lists to identify patients suitable for transfer to hub. Colorectal team to offer choice of surgeon to patient to increase flexibility around theatre schedule.
- New early diagnosis support worker appointed – will ensure use of protected CT slots.
- Pre- op teams undertaking swabs for Target patients to avoid previous delays.
- Harm reviews completed for patients past 104 days

Operations

Productivity

Analyst narrative:

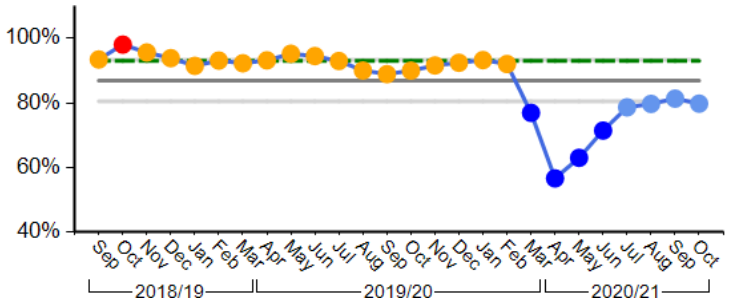
3 indicators within the Productivity section are failing to provide assurance; Bed Occupancy – ODGH, Theatre Utilisation – SDGH and Theatre Utilisation – ODGH. 4 indicators are currently showing negative variation; Bed Occupancy – ODGH, Theatre Utilisation – ODGH, DNA Rate and Southport A&E Conversion rate. Detailed action plans were produced last month to address Bed occupancy – ODGH and Theatre Utilisation and an upward performance trend is evident in October, some of which may be due to an increase in activity as the Trust continues its elective recovery.
Southport A&E Conversion Rate is currently providing assurance, but performance is on a downward trajectory therefore this indicator requires corrective action to assess the use of assessment units or seniority of clinical decision making prior to admission to inpatient beds. Whilst the DNA rate provides inconsistent assurance, a rule has been breached negatively this month, possibly impacted by an increase in Outpatient activity and the increase in Covid-19 infection rates/Tier 3 restrictions locally. Further narrative is required to understand the reasons for patient DNA's and provide remedial action.
Although Stranded and Super-Stranded patients are currently showing positive variation, these indicators are currently on a downward trajectory as the Trust faces the second wave of Covid-19 in addition to managing high A&E attendances, bed pressures and maintaining elective activity. Further operational narrative is required to provide assurance around the plans to manage 'Winter with Covid'.

Operational narrative:

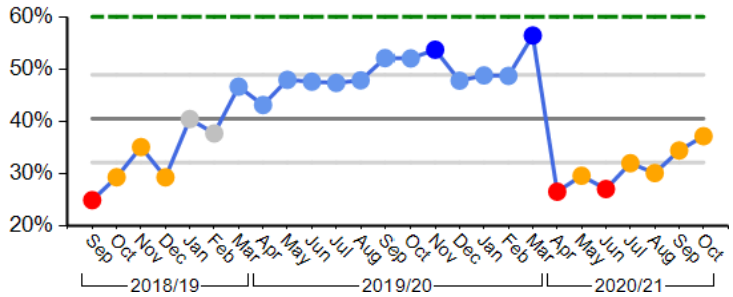
Southport A&E Conversion rate
The numbers of minors attendance has declined in recent weeks with an increased number of presentations requiring admission with COVID and non-COVID illness, this has impacted the A&E conversion rate adversely.
See also supplementary action plans for Theatre Utilisation and Bed Occupancy.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	93%	79.8%	N/A	Oct 20	L	93%	81.3%	Sep 20	93%	73%	?
Bed Occupancy - ODGH	60%	37.2%	N/A	Oct 20	L	60%	34.4%	Sep 20	60%	31%	F
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	28	28	Oct 20	L	50	40	Sep 20	50	36	?
Stranded Patients (>6 Days LOS)	170	154	154	Oct 20	L	170	145	Sep 20	170	930	?
Super Stranded Patients (>20 Days LOS)	58	46	46	Oct 20	L	58	43	Sep 20	58	294	?
New:Follow Up	2.63	2.6	N/A	Oct 20		2.6	2.4	Sep 20	2.63	2.5	?
DNA (Did Not Attend) rate	8%	7.8%	1769	Oct 20	H	8%	7.5%	Sep 20	8%	6.1%	?
Theatre Utilisation - SDGH	85%	59.6%	N/A	Oct 20		85%	57.1%	Sep 20	85%	54.9%	F
Theatre Utilisation - ODGH	95%	59.1%	N/A	Oct 20	L	95%	50.5%	Sep 20	95%	48.5%	F
Southport A&E Conversion Rate	28%	27.5%	1131	Oct 20	H	28%	25.4%	Sep 20	28%	26.8%	P

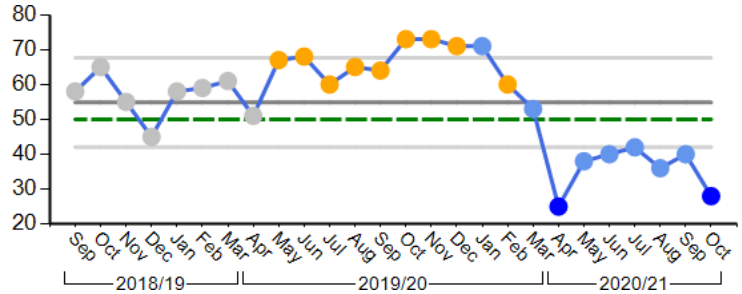
Bed Occupancy - SDGH



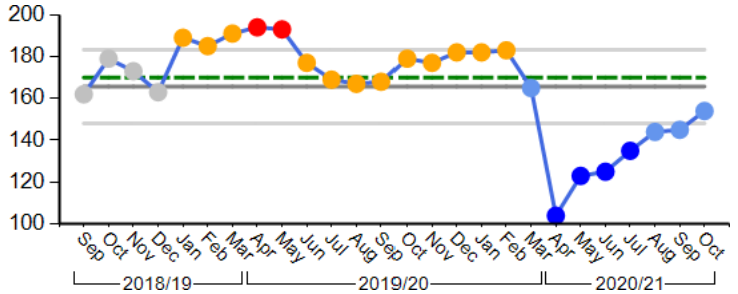
Bed Occupancy - ODGH



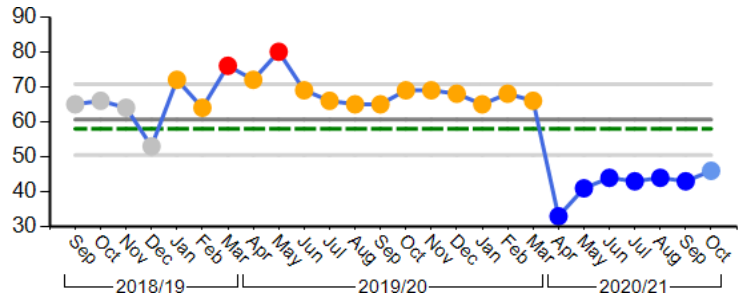
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month



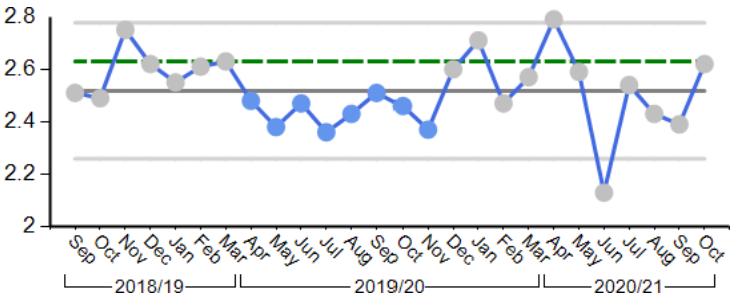
Stranded Patients (>6 Days LOS)



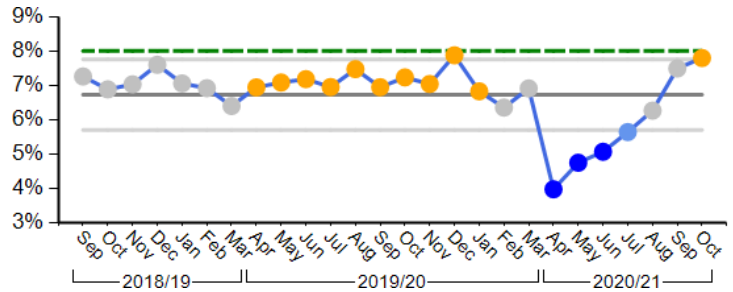
Super Stranded Patients (>20 Days LOS)



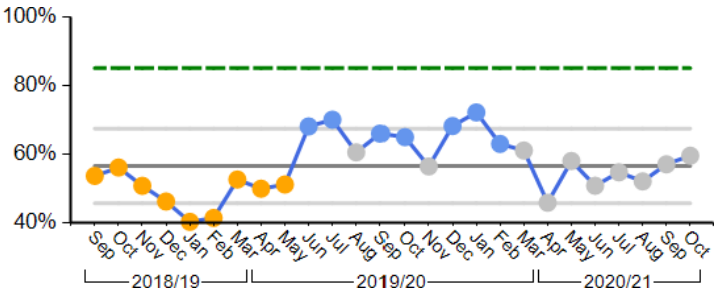
New:Follow Up



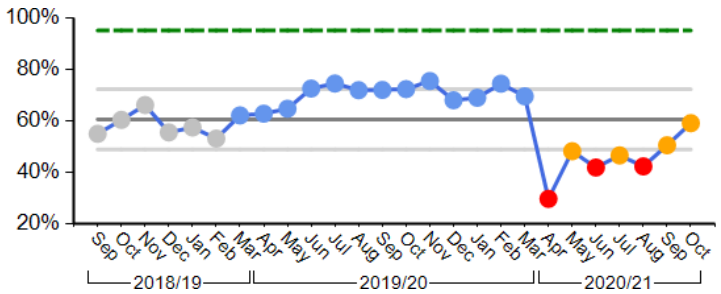
DNA (Did Not Attend) rate



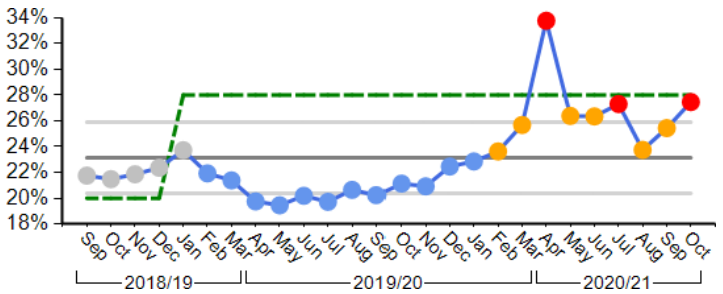
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



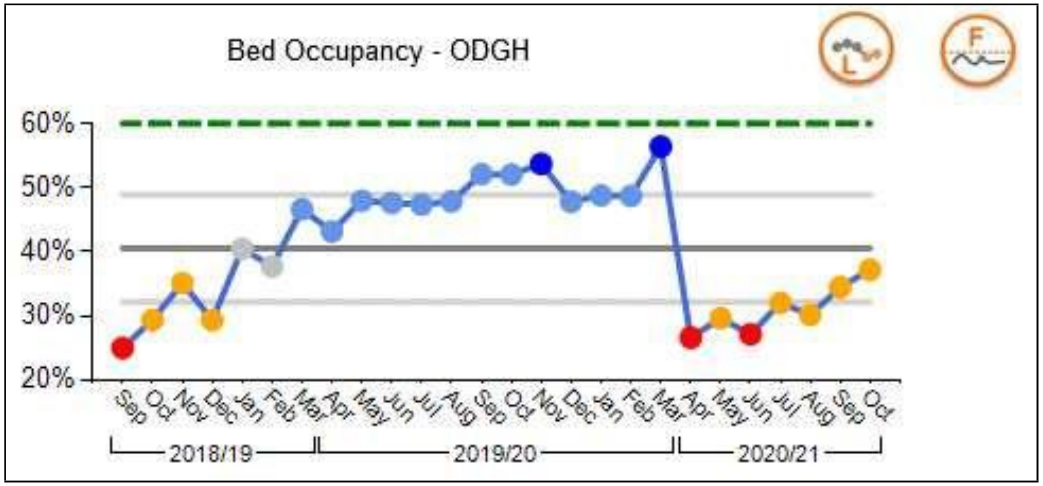
Southport A&E Conversion Rate



Bed OccupancyODGH

Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Bed Occupancy - ODGH	60%	37.2%	N/A	Oct 20	L	60%	34.4%	Sep 20	60%	31%	F



Background:

- The bed occupancy figure is average of the number of occupied beds used in the month against the number of beds available for use in the month. The overall total for the site is a combination of all the wards with general and acute beds. Where beds are used for day case patients these are excluded from the occupancy figure which is taken as a midnight position on each day.

Situation:

- Ormskirk bed occupancy is mostly reporting on the use of beds to support elective and day case admissions. Since the start of the Covid-19 recovery period this has increased slowly in line with the Trust's ability to use theatres in accordance with increased infection control protocols.
- Despite a further increase in October it remains well short of a pre-Covid baseline, which in itself was somewhat short of plan. The increase in theatre utilization at ODGH has resulted in a corresponding increase in occupancy.

Issues:

- Bed occupancy varies across wards at Ormskirk, the largest wards include E, G and H. These wards have now been reconfigured to provide ring fenced elective care (E), specialist Orthopedic rehabilitation (G) and Orthopedic theatre patients (H). E and H are currently impacted by theatre utilisation and G ward is dependent on the number of patients being admitted at Southport then transferred to Ormskirk for rehab. As Covid-19 prevalence increases at Southport these numbers have dropped and presently (in Nov) 14A is closed for admissions so G ward, by default is not receiving patients

Actions:

- List numbers are slowly increasing and General Surgery day case patients are being transferred from Southport to Ormskirk, although F ward (day case) is excluded from occupancy any patients requiring an overnight stay will be transferred to other wards which have overnight staffing.
- An extensive paper outlining changes to the configuration of Ormskirk has been provided in this month's FP&I papers to explain in more detail how occupancy is reported across both sites.

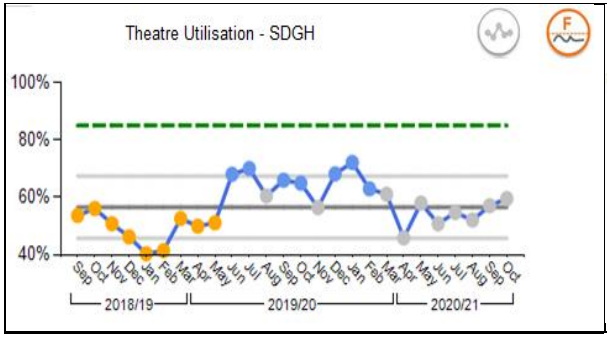
Mitigations:

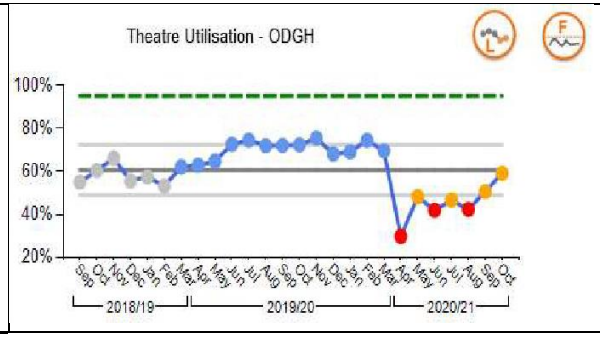
- BI have created a number of internal reports to look at ward bed occupancy on a daily and monthly basis. It also shows the constitution of activity within each ward which helps to explain how each ward is being utilised for patient care.

Theatre Utilisation

Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Theatre Utilisation - ODGH	95%	59.1%	N/A	Oct 20		95%	50.5%	Sep 20	95%	48.5%	
Theatre Utilisation - SDGH	85%	59.6%	N/A	Oct 20		85%	57.1%	Sep 20	85%	54.9%	





Background:
- The proportion elective Theatre slots used over the total elective planned capacity. Split by the site of delivery.

Situation:
- SDGH performance has failed to achieve more than 60 % since March 2020.
- ODGH performance has failed to achieve more than 50 % since March, with a YTD average of 48.5 %.
- Improvements on both sites is evident in October.

Issues:
- Despite the ongoing Covid-19 restrictions which lengthen the theatre turnaround times, an increase in Covid-19 sickness in Theatres and Theatre staff being required to support Critical Care there have been notable increases in Theatre Utilisation in October.
- Managing patient flow across the Southport site has been an issue in October with closed beds due to Covid-19. This has had a direct impact on Theatre utilisation due to bed capacity. However with increased efficiencies the Trust has managed to improve theatre utilisation across both sites.
- There remain challenges in terms of backfilling elective lists following cancellations due to isolation guidance.
- ODGH is currently managing Covid red, amber and green pathways through theatres which adds to the logical challenges causing delays.
- The Theatre Utilisation plans are considered to be unrealistic targets which cannot be achieved without a considerable Estates piece of work.

Actions:
- Issues that are under the control of the Trust are start times and underruns. Both theatres are currently impacted by poor performance in both these areas. Work has been reinvigorated in these areas and is being led by the clinicians. New specialties have now been added to the Theatre Utilisation meeting to review start and finish times for all specialties.
- The plan for this indicator on both sites requires review as it is not considered realistic or achievable.

Mitigations:
- Additional scrutiny of theatre start times and underruns, being led by clinicians and monitored weekly.
- The data is available at specialty level for review and management of performance. Oversight of specialty progress is given at the theatre efficiency meeting and reported into PIDA.

Southport and Ormskirk Hospital NHS Trust

Finance

Finance

Analyst narrative:

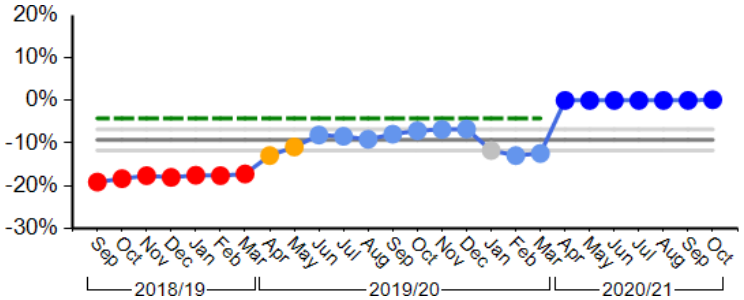
Whilst the Distance from agency spend cap is failing in its assurance measure, this is due to historical performance pre 2020/21. No agency cap has been set for 2020/21 but spend remains high. The % Agency staff (cost) whilst showing failing assurance is now in line with the mean, although the plan for this will remain a challenge throughout the winter period as the Trust faces high sickness/absence levels due to Covid. The liquidity and non-pay run rate are showing negative variation although the non-pay run rate is on an improving trajectory. The current financial agreements are impacting on most measures so assurance and variation are not entirely representative in this section of the report.

Operational narrative:

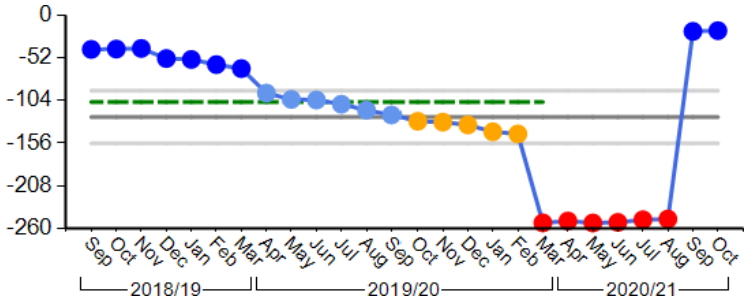
Following a break-even performance for the first half of 2020-21 the Trust was required to submit plans for months 7-12 following guidance issued by NHSE/I and the Cheshire & Merseyside Health Care Partnership (HCP). A financial plan of £1.7 million deficit has now been set for Months 7-12. The financial plan includes resource to fund additional expenditure for winter, activity restoration and Covid-19.
I&E Surplus or deficit/total revenue – a marginal surplus of 0.2% has been achieved as expenditure is phased after month 7 for winter and other items whilst income is mainly profiled equally across months 7-12. Note future tables will include planned figures from month 8 onwards following the formal revised plan submission on 18th November.
Pay – September's run rate includes the medical pay award which was back dated to 1st April. Therefore, October's spend was lower for medical staff.
Bank and agency spend – reduced marginally from September levels but consistently deliver monthly expenditure in the region of £2 million. It is difficult to see any significant improvement in the metric over the remainder of the year considering the impact COVID is having on sickness levels which will impact the winter period. Capital service capacity –no material change from September.
Liquidity - DHSC have now converted all the Trust loans into public dividend capital (PDC) resulting in an improved liquidity calculation. In practical terms there are no cash flow issues as the Trust is being paid in advance by the Commissioners and also receiving a monthly top up. The Trust's liquidity situation is unchanged from the September position.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue		0.2%	N/A	Oct 20	H	-4.2%	0%	Sep 20		0.2%	?
Liquidity		-19	N/A	Oct 20	L	-106	-20	Sep 20		-19	?
Distance from Control Total	0%	0%	N/A	Oct 20	H	0%	0%	Sep 20	0%	0%	?
Capital Service Capacity		3.12	N/A	Oct 20	H	0.2	4.15	Sep 20		3.12	?
% Agency Staff (cost)	5%	7.7%	N/A	Oct 20		5%	7.8%	Sep 20	5%	8%	F
Use of Resources (Finance) Score	3	2	N/A	Oct 20	L	3	2	Sep 20		3	?
Distance from Agency Spend Cap	0%	0%	N/A	Oct 20	L	0%	0%	Sep 20	0%	0%	F
Pay Run Rate - Trust		£12,633K	N/A	Oct 20			£12,848K	Sep 20		£86,439K	?
Non Pay Run Rate - Trust		£5,154K	N/A	Oct 20	H		£5,307K	Sep 20		£34,757K	?
Bank & Agency Run Rate - Trust		£2,028K	N/A	Oct 20			£2,078K	Sep 20		£14,685K	?

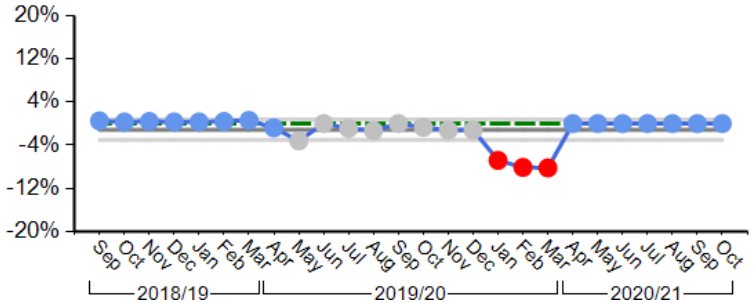
I&E surplus or deficit/total revenue



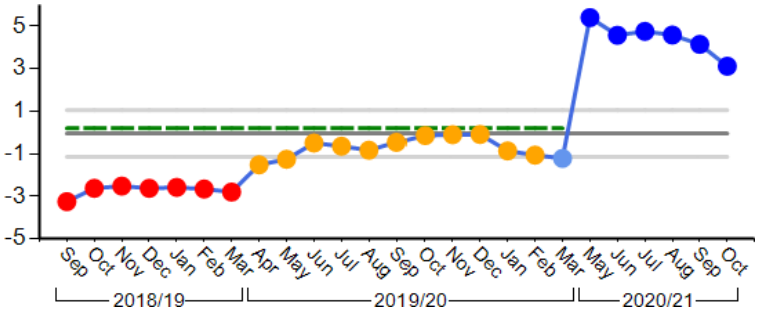
Liquidity



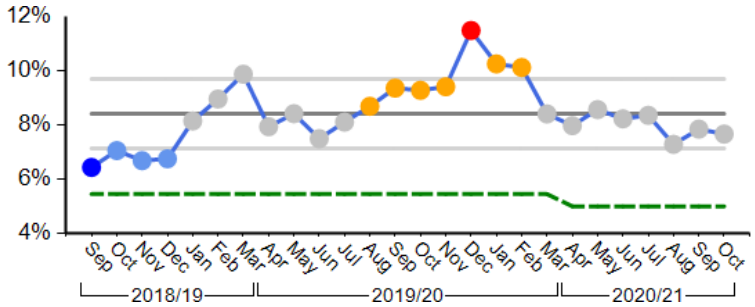
Distance from Control Total



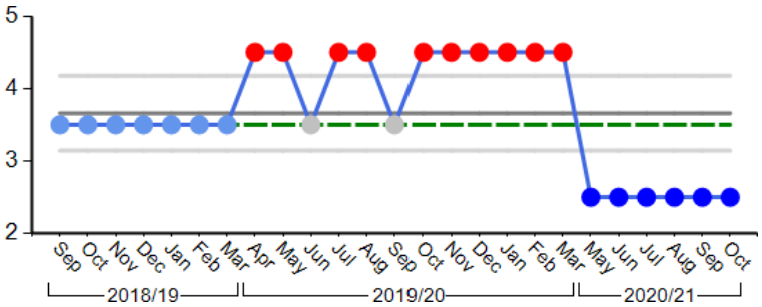
Capital Service Capacity



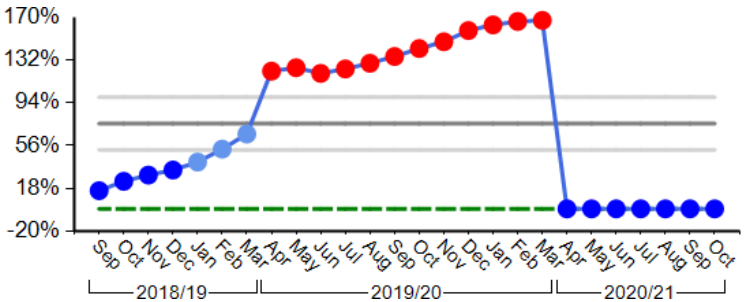
% Agency Staff (cost)



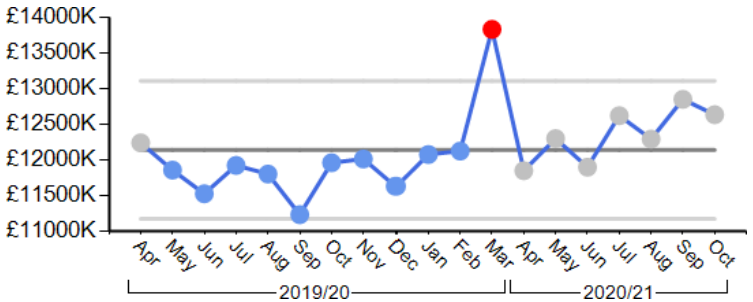
Use of Resources (Finance) Score

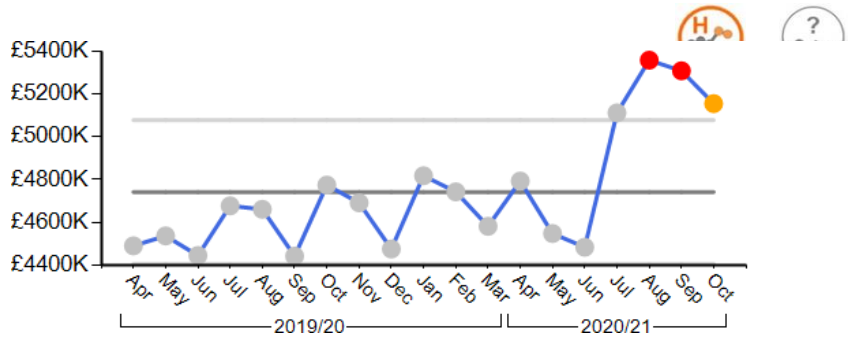


Distance from Agency Spend Cap

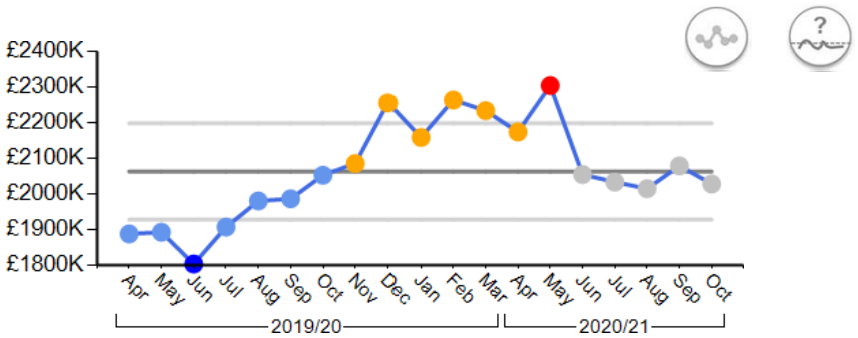


Pay Run Rate - Trust





Non Pay Run Rate - Trust



Bank & Agency Run Rate - Trust

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group	Workforce Committee
Meeting date:	24 November 2020
Lead:	Pauline Gibson

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence
The Sickness Absence rates for all staff groups; Medical, Nursing, AHPs/Therapies and Non-Clinical Staff have all increased in month and have not met their planned targets. This has increased due to COVID-19: and there is also increased absence due to bereavement and for non-work-related stress. The Committee additionally discussed amending the Sickness Absence rate target for Nursing staff which is currently at 4%. After much deliberation, the Committee proposed the following recommendation that this target is amended to 5% (see below re IPR recommendations) whilst cognisant of any impact on establishment planning. Model hospital was used to identify this challenging yet realistic target.

ADVISE

Risk Register – Clinical Competency Working Group and Review of Skills Matrix
Due to the significance of Clinical Education high level risks, the current Head of Education, Training and Organisational Development (HOET) has been commissioned to dedicate their full time to this issue from the December 2020. Furthermore, the Deputy Director of Nursing and the HOET will be undertaking a full scale review in November 2020 to finalise the essential skill matrix for staff.

Staff Turnover
The rates of Staff Turnover in month are mixed. The overall annual rate is on an improving trajectory (adversely affected by a peak in Aug 20 which was due to the cessation of Healthcare Assistant fixed term contracts). The Committee requested staff retention rates to become a metric within the IPR.

Emerging Risk – Retention of Nurses
There is currently an emerging risk related to the retention of nurses. This is not only due to COVID-19, but also to the number of fixed term contracts in the organisation and the staff turnover rates in the Nursing and Midwifery staff group. Focus is being given to exploring the retention of those on a fixed term contract as well as improving the poor uptake of exit questionnaires. The importance of regular conversations to identify potential leavers at the earliest opportunity was reinforced and linked to the PDR review.

IPR Review
Following ongoing discussions on the IPR measures for Agency Staff Cost, Sickness rate, Staff turnover and Medical Vacancy rate the Committee recommended further work on some of the suggested changes and supported changes to other targets within the IPR. Those recommendations will be fed into the wider IPR full scale review which is due to Board in February.

Time to Hire (TTH)
The current TTH in month is 60.58 days compared to 58.43 days in September. It was noted that whilst there is a lot of focus on trying to improve the figure, there is limited assurance. Capacity of key individuals within the Recruitment and Selection process is proving

challenging during this second wave and some improvement activities have had to be paused. It is noted that progress is still being made on maximising the electronic recruitment system.

ASSURE

MIAA Audit
It was reported that there is substantial assurance around training records management from the MIAA audits held from September 2018 to October 2020

NHSP Partnership
There is a significantly improved relationship between the Trust and NHSP whereby fill rate has increased higher than at any given time in the past. It was noted NHSP are involved in the Trusts daily safe staffing meeting and its international recruitment process. The Trust is expanding its bank to Admin and Clerical support services.

PDR Deep Dive
The Chair commended the ongoing work on the PDR Deep Dive analysis. The Committee thoroughly discussed that the surveys undertaken highlighted significantly some of the most important issues into why PDRs aren't considered meaningful. The Deep Dive analysis is due for final approval and sign off in December 2020.

Critical Care – Nursing Times Award
The Committee formally congratulated the Critical Care Unit for achieving the Nursing Times Award.

Flu Vaccinations Campaign
The current percentage of Flu vaccinations taken by patient facing members of staff is 81%.

Formal Thank You
A formal thank you was granted to each and every one of the Trust's workforce for the effort over the last year. The Workforce Committee stated they recognise how tough it has been and admire the determination and care that has been exhibited in many different ways by all staff.

New Risk identified at the meeting	None.

Review of the Risk Register:

NHS
Southport and Ormskirk Hospital
NHS Trust

Workforce

Agency

Analyst narrative:

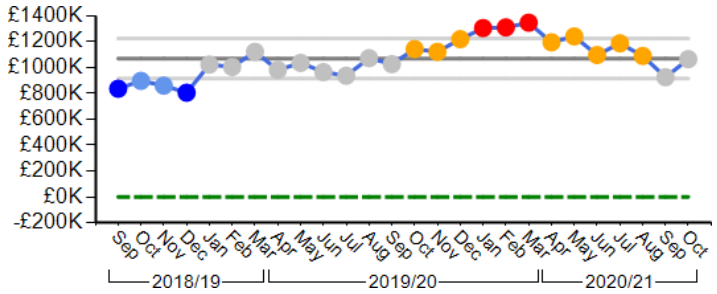
The expenditure on bank/agency staff whilst showing failing assurance is now in line with the mean, although the plan for this will remain a challenge throughout the winter period as the Trust faces high sickness/absence levels due to Covid.

Operational narrative:

Bank and agency spend – reduced marginally from September levels but consistently deliver monthly expenditure in the region of £2 million. It is difficult to see any significant improvement in the metric over the remainder of the year considering the impact COVID is having on sickness levels which will impact the winter period.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Expenditure on Bank / Agency Staff	£00K	£1,063K	N/A	Oct 20	H	£00K	£924K	Sep 20		£7,791K	F

Expenditure on Bank / Agency Staff



Workforce

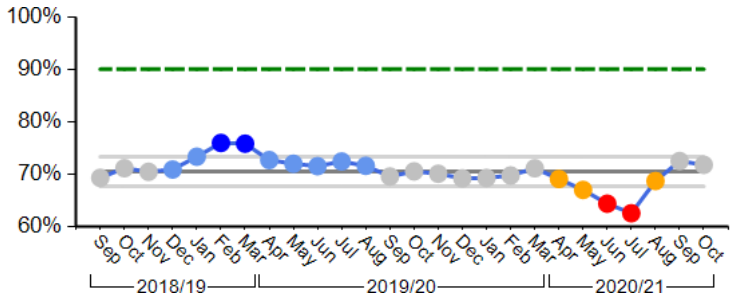
Organisational Development

Analyst narrative:
Personal Development Reviews remain a cause for concern with failing assurance and negative variation in recent months. Further narrative/action is required to provide further assurance. Mandatory training is now providing assurance as it continues to perform ahead of plan. This performance needs to be sustained. A new indicator has been added this month to reflect the Staff Friends and Family Test - % who would recommend as a place to work. The plan is based upon the average figure for the Cheshire and Merseyside region. The Trust performed ahead of this plan in the latest survey (Q4 2019/20). The Staff Friends and Family Test is currently suspended due to Covid-19.

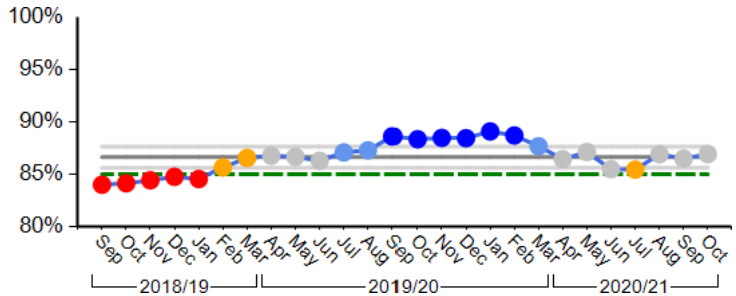
Operational narrative:
Personal Development Reviews remain a cause for concern in terms of compliance and quality. An appraisal deep dive analysis is in progress for a 3 month period with a final report & recommendations for review at Workforce Committee 15/12/2020. The recommendations will form the basis of an action plan to address compliance and quality. The work of the Clinical Competency Working Group has been delayed due to urgent clinical commitments, in its place the Deputy Director of Nursing and Head of Education & Training will undertake a review in Nov 2020 to finalise the essential skills training matrix and fast track the supporting training needs analysis. The MIAA draft report (Oct 2020) shows substantial assurance around training records management and new monthly quality checks have been established to ensure data accuracy. Once re-established nationally, the Trust will commission Quality Health to run the 3 x per year staff FFT alongside the NHS Staff Survey.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	90%	71.8%	N/A	Oct 20		90%	72.5%	Sep 20	90%	69.1%	
Mandatory Training	85%	86.9%	N/A	Oct 20		85%	86.5%	Sep 20	85%	86.4%	
Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall	67%	74.5%	N/A	Mar 20		67%	63.6%	Jul 19	67%	69.9%	

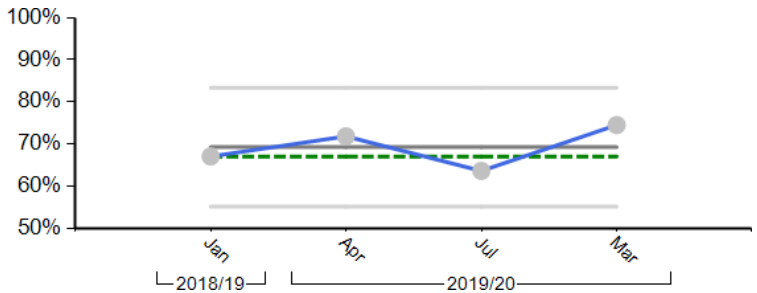
Personal Development Review



Mandatory Training



Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall



Workforce

Sickness, Vacancy and Turnover

Analyst narrative:

6 indicators are currently failing to provide assurance, relating to sickness, turnover and vacancy rates. Rolling staff turnover, whilst on an improving trajectory, continues to be adversely affected by the spike in August. The rolling sickness rate is shows recent negative variation with increases in October as the workforce is impacted by the second wave of Covid-19. Vacancy rates continue to perform significantly higher than plan although marginal reductions are evident in October.

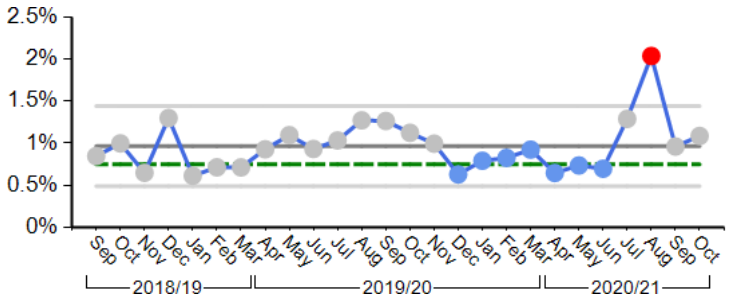
Operational narrative:

The overall annual turnover rate for the Trust has remained steady over the course of the 12 month period (at its highest in August 2020 mainly due to the cessation of Healthcare Assistant fixed term contracts). In the majority of staff groups, there have been more starters over the course of the year than have left, with the exception of the nursing and midwifery staff group. In order to bring turnover more in line with the target and regional rates, the potential to retain those staff employed on fixed term contracts is being explored as well as addressing turnover amongst nursing and midwifery staff groups. The current poor uptake of completion of exit questionnaires (12.61%) is limiting the ability to fully understand the reasons why people are leaving beyond 'work/life balance', and there will be a renewed drive to improve this.
Sickness absence is increasing and resilience of the workforce is being challenged with the second wave of Covid-19, as the main reason for non-covid related absence is stress / anxiety / depression). From a Trust-wide perspective, supporting staff, particularly patient facing and those deemed as 'clinically extremely vulnerable' is a key priority over the coming months, through welfare conversations, the redeployment initiative, launch of a refreshed wellbeing offer, flu vaccination programme (at 75% healthcare workers vaccinated to date) and asymptomatic staff swabbing exercise (most recent exercise resulted in 93% patient facing staff swabbed and 1.64% returning as positive). The Trust now awaits the responses to the staff survey (42% response rate to date) to evaluate the impact of the support offered to staff during the pandemic and strengthen this offer to staff further as we enter the Winter. Where sickness absence is prevalent in specific departments, plans are in place to address this.

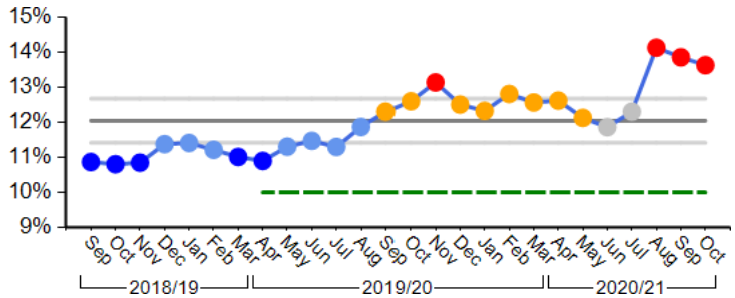
Recruitment activity for nursing continues as planned, however, the target establishment for October 2020 was not met due to the delays in obtaining pins for student nurses under offer and more leavers in September and October than projected. Although successful bids through NHSE/I and offers from recruitment events in November to date mean the next milestone in March 2021 is on track to be met. In terms of medical recruitment, the Trust is about to commence a refreshed consultant recruitment campaign with an improved attraction approach and potential to offer joint appointments with Edge Hill University. Job planning is well underway across all departments and the service planning process in Urgent Care has highlighted challenges in delivering against demand with the current consultant establishment.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Staff Turnover	0.75%	1.1%	N/A	Oct 20	H	0.8%	1%	Sep 20	9%	6.8%	?
Staff Turnover (Rolling)	10%	13.6%	N/A	Oct 20	H	10%	13.8%	Sep 20			F
Vacancy Rate - Medical	5%	10.7%	N/A	Oct 20		5%	12.5%	Sep 20	5%		F
Vacancy Rate - Nursing	8%	14%	N/A	Oct 20		8%	15%	Sep 20	8%		F
Sickness Rate	4%	6.8%	N/A	Oct 20		4%	5.6%	Sep 20	5%	6.5%	?
Sickness Rate (Rolling 12 Month)	4%	6.2%	N/A	Oct 20	H	4%	6%	Sep 20	4%	5.9%	F
Time to Recruit	55	61	N/A	Oct 20		55	58	Sep 20	55	55	?
Sickness Rate - Medical Staff	4%	2.7%	N/A	Oct 20		4%	2.5%	Sep 20	4%	3.4%	?
Sickness Rate - Nursing Staff	3.7%	8.4%	N/A	Oct 20		3.7%	7.3%	Sep 20	3.7%	8%	F
Sickness Rate - Non-Clinical Staff	4%	6.1%	N/A	Oct 20		4%	4.8%	Sep 20	4%	5.7%	F
Sickness Rate (not related to Covid 19) - Trust	4%	5.5%	N/A	Oct 20	H	4%	5.3%	Sep 20	4%	4.6%	?

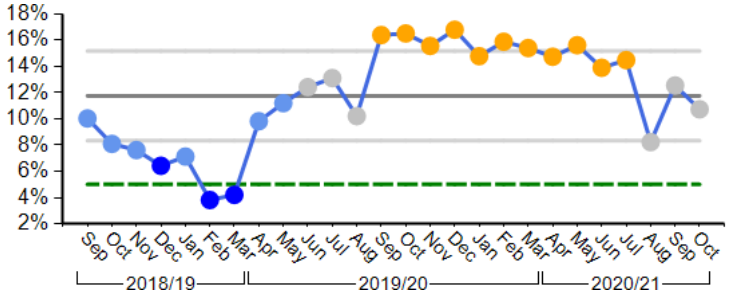
Staff Turnover



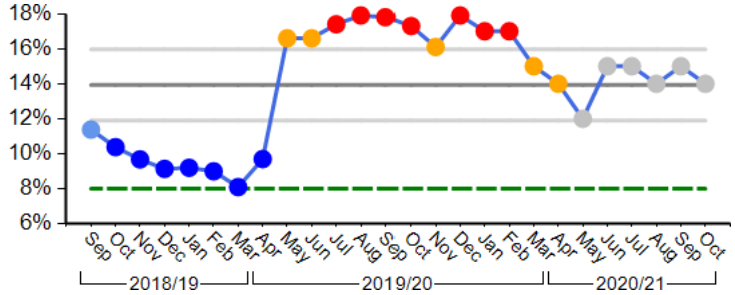
Staff Turnover (Rolling)



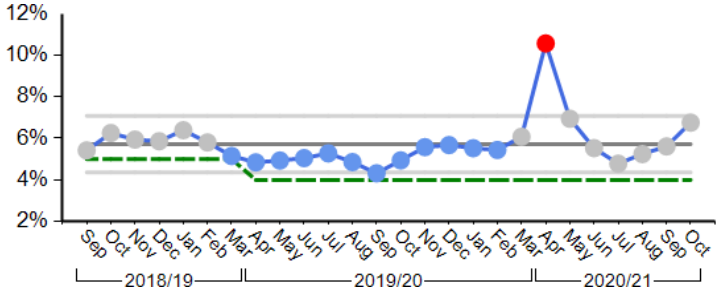
Vacancy Rate - Medical



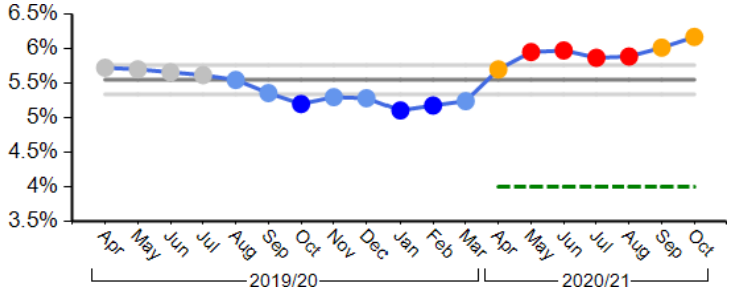
Vacancy Rate - Nursing



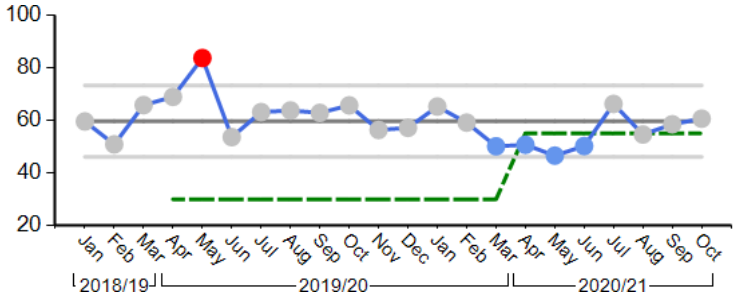
Sickness Rate



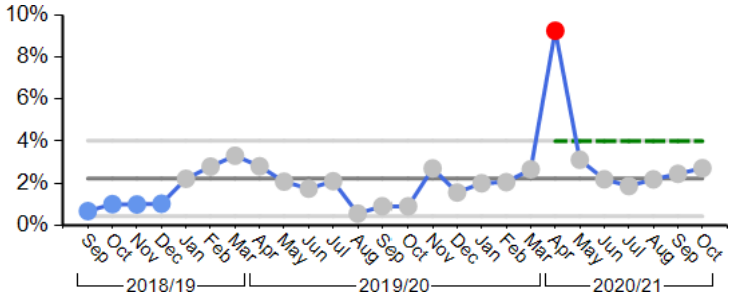
Sickness Rate (Rolling 12 Month)



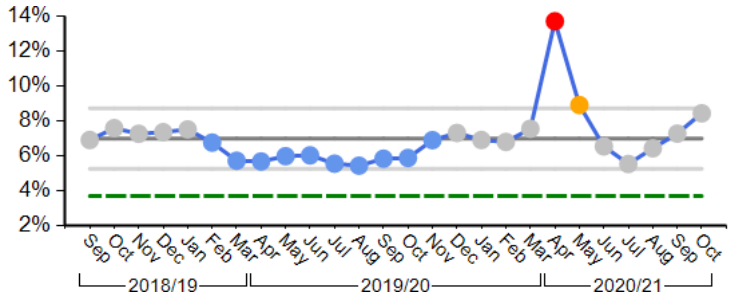
Time to Recruit



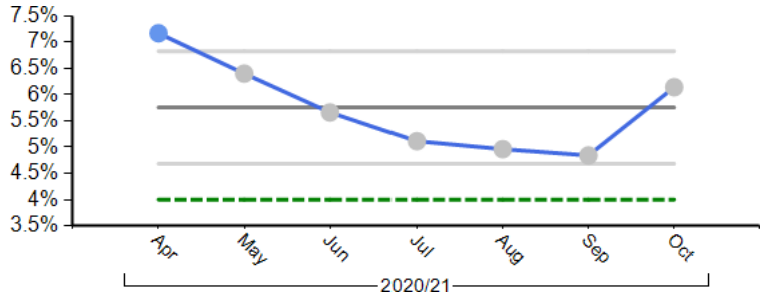
Sickness Rate - Medical Staff



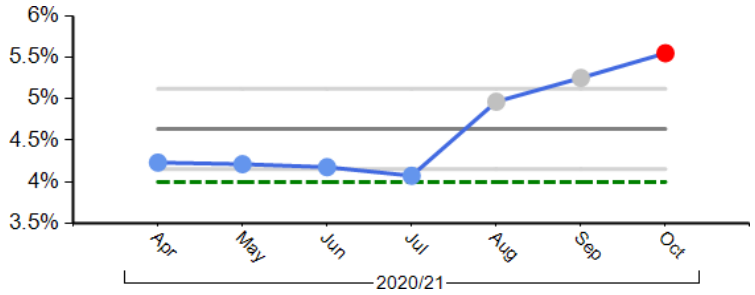
Sickness Rate - Nursing Staff



Sickness Rate - Non-Clinical Staff



Sickness Rate (not related to Covid 19) - Trust



Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB201/20a**	**FOI Exempt**	**NO**
Report Title	**CORPORATE GOVERNANCE REPORTS** Scheme of Reservation and Delegation		
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 present the updated Scheme of Reservation and Delegation following review.

Executive Summary

The Trust's Corporate Governance policies are periodically reviewed to ensure that they reflect changes in legislation, directives from regulator and that they remain aligned to management decisions within the Trust. The Scheme of Reservation and Delegation was last presented to the Board as part of the annual review in June 2020 and is now presented for approval following an update.
Notable changes to bring to the Board's attention are as follows:

a) S.9 (SFI Ref 221.1 and 22.2) have been amended from Medical Director to Director of Finance
b) S.10.2 previously referred to the COO as the second non-voting director on the Board, this has now been amended to reflect that there is a single non-voting director
c) S.10.9 – Operation scheme of Reservation and Delegation
    - ss.4c and 4d have been updated so the virement rules can distinguish between recurrent and non-recurrent budget transfers as previously they only permitted non-pay transfers. This insertion also reflected in the Financial Management Framework.
    - ss.5c – changed from DCEO to Director of Finance to reflect change in portfolios
    - ss19d and 19f – replaced ADHR with Director of HR and OD
    - ss.20b – amended to Drugs and Therapeutics Group

Recommendations

The Board is asked to **receive** and **approve** the amendments to the Scheme of Reservation and Delegation.

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

Southport and Ormskirk Hospital NHS Trust

Prepared By:	Presented By:
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Southport and Ormskirk Hospital NHS Trust

Scheme of Reservation and Delegation 2020/21

Southport and Ormskirk Hospital NHS Trust

CONTENTS

1 Introduction

1.1 For effective governance, the Board of Directors must have in place arrangements to ensure that there is clarity about how decisions are made and who makes them.

1.2 No matter how effective the Board of directors may be, it is not possible for it to have hands-on involvement in every area of the organisation's business. An effective Board controls the business but delegates day to day responsibility to executive management. That said, there are a number of matters which are required to be or, in the interests of the company, should only be decided by the Board of directors as a whole. It is incumbent upon the Board to make it clear what these matters reserved for the Board are.

1.3 *The UK Corporate Governance Code* states that *'There should be a formal schedule of matters specifically reserved for [the Board's] decision' and that the annual report should contain a 'high level statement of which types of decisions are to be taken by the Board and which are to be delegated to management.'*

1.3 The Trust's *Standing Orders* (SO4.1) and the *NHS Code of Conduct* and *Code of Accountability* require that the Trust:

- Clearly identifies the types of decisions which are to be reserved for the Board; and
- Ensures that arrangements are in place to enable responsibility for other decisions to be clearly delegated to executive management, officers, and committees.

1.4 The formal *Scheme of Reservation and Delegation* outlines the decisions reserved for the Board and those delegated to Committees and officers.

1.5 The formal *Scheme of Reservation and Delegation* details those decisions which the Board delegates to officers through the Executive Management Structure and to Committees through the Governance Structure.

1.6 The purpose of the *Scheme of Reservation and Delegation* is to empower Directors, and those managers who have been given authority to act on their Directors' behalf, to take appropriate decisions within a robust corporate framework.

1.7 The Board remains accountable for all of its functions even those delegated to Committees, individual Executive Directors and Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2 Role of the Chief Executive

2.1 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to an assurance committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive.

2.2 All powers delegated by the Chief Executive can be re-assumed by the Board should the need arise. As Accountable Officer, the Chief Executive is accountable to the Department of Health for the funds devolved to the Trust.

3 Considerations when Using Delegated Powers

3.1 Powers are delegated to officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

3.2 All those exercising authority delegated by this framework have a duty to observe the wider regulatory framework outlined in the following:

- *Standing Orders*
- *Standing Financial Instructions*
- *Standards of Business Conduct and Managing Conflicts of Interest*
- *Fit and Proper Persons' Regulations*
- *Trust Policies*

3.3 It will be the responsibility of each Executive Director to ensure that those staff members to whom they have delegated authority to exercise decision making powers are capable and competent to do so.

3.4 Although the Trust operates with a number of Directorates, it is vital that Directorate Managers and Service Leads recognise that their area of responsibility is an integral part of the Trust and they should not therefore act in the interests of their Directorate alone but in the interests of the corporate Trust.

4 Absence of Directors or Officers to Whom Powers have been Delegated

4.1 In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless formal acting up arrangements have been put in place or alternative arrangements have been approved by the Board of Directors.

4.2 In the Chief Executive's absence, powers delegated to them may be exercised by the nominated officer acting in their absence usually the Deputy Chief Executive.

4.3 If it becomes clear to the Board of Directors that the Accountable Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accountable Officer, usually the Deputy Chief Executive, pending the Accountable Officer's return. The same applies if, exceptionally, the Accountable Officer plans an absence of more than four weeks during which they cannot be contacted.

5. Scheme of Reservation and Delegation

5.1 Accountability

5.1.1 The *NHS Code of Conduct and Code of Accountability* which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto it. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in paragraphs 5.4 to 5.10 below.

5.1.2 Decisions reserved to the Board generally represent matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions; even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

5.2 Duties

5.2.1 It is the Board's duty to:

- act within statutory financial and other constraints.
- be clear what decisions and information are appropriate to the Board of Directors and draw up *Standing Orders*, Standing Financial Instructions and a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these.
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account.
- establish performance and quality measures that maintain the effective use of resources and provide value for money.
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities.
- establish Audit and Remuneration & Nominations Committees based on formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting to the main Board.

5.3 General Enabling Provision

5.3.1 The Board of Directors may determine any matter, (for which it has authority), it wishes in full session within its statutory powers.

5.4 Regulations and Control

The Board of Directors has reserved the following powers unto itself:

5.4.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and *Standing Financial Instructions* for the regulation of its proceedings and business.

5.4.2 Suspend the *Standing Orders*.

5.4.3 Vary or amend the *Standing Orders.*

5.4.4 Note any urgent decisions taken by the Chair and Chief Executive in accordance with SO4.3.

5.4.5 Approval of a *Scheme of Delegation of Powers* from the Board of Directors to Committees and officers.

5.4.6 Receiving the declaration of Board members' interests which may conflict with those of

the Trust's business and determining the extent to which that director may remain involved with the matter under consideration.

5.4.7 Approval of the disciplinary procedure for officers of the Trust.

5.4.8 Disciplining Directors who are in breach of statutory requirements of the *Standing Orders or Standing Financial Instructions.*

5.4.9 Approval of arrangements for dealing with complaints.

5.4.10 Adoption of the Trust's organisational structures, processes and procedures to facilitate the discharge of Trust's business and to agree any significant modifications.

5.4.11 Receiving reports from assurance and statutory Committees and to take appropriate action thereon.

5.4.12 Approving the recommendations of the Trust's Committees where the Committees themselves do not have executive powers.

5.4.13 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust.

5.4.14 To approve terms of reference and reporting arrangements of all committees established by the Board of Directors.

5.4.15 Approve arrangements to enable the Trust to discharge its responsibilities as a 'bailer' for patients' property.

5.4.16 Authorise the use of the Trust's Seal in a transparent and honest way to avoid collusion and corruption.

5.4.17 Ratify or otherwise instances of failure to comply with *Standing Orders* brought to the Chief Executive's attention in accordance with *Standing Orders*.

5.4.18 Approve the Trust's Major Incident Plan.

5.5 Appointments

5.5.1 Appoint the Vice Chair of the Board of Directors.

5.5.2 Appoint the Senior Independent Director.

5.5.3 The establishment and disestablishment of committees of the Board.

5.5.4 The appointment of members of committees of the Board.

Dismissals

5.5.5 The dismissal of Executive Directors and the Company Secretary or equivalent.

5.6 Policy Determination

5.6.1 The approval of Human Resources policies incorporating the arrangements for the appointment, dismissal, and remuneration of staff.

5.6.2 The approval of the *Raising Concerns (Whistleblowing) Policy.*

5.6.3 The approval and monitoring of the *Risk Management Strategy.*

5.7 Strategy and Business Plans and Budgets

5.7.1 Definition of the strategic aims and objectives of the Trust.

5.7.2 Approval annually of plans in respect of the application of available financial resources.

5.7.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

5.7.4 Approve the Capital Expenditure Programme.

5.7.5 Approve budgets.

5.7.6 Approve the *Annual Business Plan* for submission to the Independent Regulator, which includes:

- Assumptions on service delivery requirements
- Contract and associated income assumptions
- Expenditure plans and associated assumptions
- Savings plans on revenue
- Capital Expenditure Programmes
- Plans for managing working capital and cash
- Any non-revenue financing arrangements.

5.8 Direct Operational Decisions

5.8.1 Acquisition, disposal or change of use of land and/or buildings.

5.8.2 Approve Private Finance Initiative (PFI) proposals.

5.8.3 The introduction or cessation of any significant action or operation. An activity or operation shall be regarded as significant if it has gross annual income or expenditure in excess of £2.5m.

5.8.4 Approval of any contracts, including purchase orders (other than NHS contracts) amounting to, or likely to amount to, over £500,000 per annum or £2.5m in total.

5.8.5 Approval of individual losses write offs and special payments in line with the Standing Financial Instructions.

5.8.6 Agreeing action on litigation not covered by the NHS Resolution risk pooling schemes.

5.9 Financial and Performance Reporting Arrangements

5.9.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust including but not limited to finance, quality, workforce and operational performance.

5.9.2 Ensure there is oversight, at least in summary form, of monitoring returns required by the Independent Regulators.

5.9.3 Receipt and approval of the Trust's *Annual Report and Annual Accounts*.

5.9.4 Receipt and approval of the *Annual Report and Annual Accounts* for funds held on Trust.

5.9.5 Approval of the opening or closure of any bank or investment account.

5.10 Audit Arrangements

5.10.1 To approve audit arrangements (including arrangements for separate audit funds held on trust) and receive reports of the Audit Committee meetings and take appropriate action:

5.10.2 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.

5.10.3 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

6 Scheme of Reservation and Delegation of Powers

6.1 Delegation to Committees

6.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition, terms of reference and reporting requirements of such committees will be approved by the Board of Directors.

6.1.2 In accordance with the Standing Orders committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

6.2 Delegation to Officers

6.2.1 The *Trust Standing Orders and Standing Financial Instructions* set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors.

6.2.2 The following responsibilities are derived from the *Accountable Officer Memorandum for Chief Executives of NHS Trusts:*

6.2.3 The Accountable Officer has responsibility for ensuring that the Trust carries out its' functions in a way that ensures proper stewardship of public money and assets.

6.2.4 The specific personal responsibilities of a Trust's Accountable Officer:

- The propriety and regularity of the public finances for which they are answerable
- The keeping of proper accounts
- Prudent and economical administration

- The avoidance of waste and extravagance; and
- The efficient and effective use of all the resources in their charge

6.2.5 Accountable Officers must make sure that their arrangements for delegation promote good management and are supported by the necessary staff with an appropriate balance of skills.

6.2.6 This Scheme of Reservation and Delegation only covers matters delegated by the Board to the Chief Executive and by the Chief Executive to the Executive Directors and Company Secretary or equivalent, as well as specific matters set out in the *Standing Orders and Standing Financial Instructions.*

7.0 Relationship of the Scheme of Reservation and Delegation to Organisational Structure

7.1 Each Director is responsible for the delegation within their Directorate and should produce a *Directorate Scheme of Reservation and Delegation* to this effect.

7.2 The *Directorate Scheme of Reservation and Delegation* should be aligned to the *Operational Scheme of Reservation and Delegation* regarding financial matters set out in **10.9.**

8.0 Scheme of Reservation and Delegation aligned with the Trust's Standing Orders

SO Ref	Delegated to	Duties Delegated
1.2.2	Chair	Final authority in the interpretation of the *Standing Orders.*
1.6.1	Chief Executive	Ensure that existing officers and new officers are notified of, and understand, their responsibilities set out in the *Standing Orders and Standing Financial Instructions.*
2.11.3.1	Director of Finance	Responsible for the provision and supervision of financial control and accounting systems.
2.11.6	Chair	Chair all Board meetings (and associated responsibilities).
3.2	Chair	Call meetings of the Board of Directors.
4.3	Chair and Chief Executive in consultation with two Non-Executive Members	Exercise the emergency powers of the Board.
7.4	Company Secretary or equivalent	Maintain a Register of members' and other officers' Interests.
8.1 and 8.3	Company Secretary or	Keep the Trust Seal in a safe place and maintain a register of sealings.

	equivalent	
8.4.1	Chief Executive / Executive Members / Company Secretary or equivalent	Approve and sign all documents which will be necessary in legal proceedings.
8.4.3	Chief Executive / Executive Members / Company Secretary or equivalent	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
9.1	Company Secretary or equivalent	Accept service of all legal proceedings on behalf of the Trust via a *Freedom to Engage Process*
9.2	Company Secretary or equivalent	Authorised to instruct solicitors to advise the Trust or defend the Trust, or in the matter of formal dispute resolution procedures.

9.0 Scheme of Reservation and Delegation aligned with the Standing Financial Instructions

SFI Ref	Delegated to	Duties Delegated
1.5.5	Chief Executive	Ensure all officers, present and future, are notified of, and understand, the *Standing Financial Instructions*.
1.5.6	Director of Finance	Responsible for implementing the Trust's financial policies and co-ordinating corrective action, and ensuring detailed financial procedures and systems are prepared and documented.
1.5.6	Director of Finance	Maintain appropriate systems of financial control and record keeping in line with the requirements of the regulators.
1.5.7	All Directors and officers	Responsible for the security of Trust property, avoiding loss, exercising economy and efficiency in using resources and conforming to *Standing Orders, Standing Financial Instructions* and financial procedures.
2.1	Audit Committee	Provide an independent and objective view on the system of internal control and probity, including assurance statements.
2.1.4	Director of Finance	Ensure adequate internal and external audit services (in accordance with NHS Internal Audit Standards).
3	Director of Finance	Ensure there are adequate counter-fraud and corruption arrangements, including the investigation of cases of fraud or other irregularity.
4	Director of Finance	Ensure adequate security management arrangements.
5.1.1	Chief Executive	Overall responsibility for financial management and the Trust operating within resource limits.
5.1.2	Director of Finance	Submit financial plans and any adjustments to previously agreed financial plans for Board approval.
5.1.2	Director of Finance	Providing financial reports to the regulator.
5.2	Chief Executive	Preparation of Annual Business Plan.
5.2.3	Director of Finance	Monitor performance against plans and budget and submit to Board financial estimates and forecasts.
5.2.6	Director of Finance	Ensure adequate training for budget holders.
5.3.1	Chief Executive	Delegate budget to budget holders.
5.4.1	Director of	Devise and maintain system of budgetary control.

	Finance	
5.4.3	Chief Executive	Cost Improvement Plans and income generation initiatives.
6.1	Director of Finance	Responsible for the preparation and publishing of the Annual Accounts.
6.2	Company Secretary or equivalent	Responsible for the preparation and publishing of the *Annual Report.*
7	Director of Finance	Trust Banking Arrangements.
8	Director of Finance	Income systems including debt recovery.
9.1	Chief Executive	Ensure the Trust enters into appropriate *Service Level Agreements* for the provision of services and report performance against such to the Board.
10.1.2	Remuneration Committee	Agree remuneration and terms of service for Executive Members and Company Secretary or equivalent.
10.4	Director of Finance and Director of HR & OD	Appropriate processing of payroll.
10.5	Director of HR & OD	Responsible for ensuring all officers have a contract of employment.
10.8.7	Director of HR & OD	Approve all decisions to offer an involvement payment to a volunteer or lay member, ensuring records of kept of any such payments.
11.1.1	Chief Executive	Determine, and set out, the level of delegation of non-pay expenditure to budget managers.
11.2.2	Director of Finance	Prompt payment of appropriately authorised supplier accounts and invoices.
11.2.7	Director of Finance	Ensure that arrangements for the financial control and audit of building and engineering contracts comply with best practice.
12	Director of Finance	Advise the Board on borrowing and investment needs and prepare procedural instructions.
13.2.6	Director of Finance	Developing procedures for monitoring the capital programme.
13.7.1	Chief Executive	Overall responsibility for assets.
13.7.2	Director of Finance	Maintenance of asset registers, including the register of properties.
13.7.11	Director of Finance	Calculate and pay capital charges in accordance with the Independent Regulator's requirements.
13.8.4	All Staff	Responsibility for the security of Trust assets including reporting losses in accordance with Trust procedure.
14.6	Director of	System of control over stores and receipt of goods.

	Finance	
15	Director of Finance	Preparing procedures for recording and accounting for losses and special payments and for management of all frauds/thefts.
16.1	Director of Finance	Ensure procurement procedures are compliant with legislation and HMT Managing Public Money.
16.4.1	Chief Executive	Determining exceptional circumstances under which the formal tendering processes can be waived.
16.5.8	Chief Executive	Nomination of an officer to maintain a list of approved firms who may be invited to tender or provide a quote.
16.5.9	Chief Executive	Approve the use of firms not on the list of approved contractors.
16.11.1	Chief Executive	Nominate officers with delegated authority to enter contracts for employment of other officers, to authorise re-grading of staff, and enter into contracts for the employment of agency staff or temporary staff.
16.12.1	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.
16.14.1	Chief Executive	Demonstrate best value for money for all in-house services provided.
16.14.5	Chief Executive	Nominate an officer to oversee and manage each contract on behalf of the Trust.
17.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and procedures on admission.
18.1.7	Director of Finance	Ensure each fund held on Trust is managed appropriately.
19.1	Company Secretary or equivalent	Ensure all staff are aware of the Trust's Policy for the Standard of *Business Conduct and Managing Conflict of Interest Policy.*
19.2	Company Secretary or equivalent	Maintain a Register of Gifts and Hospitality and Sponsorships.
19.3	Company Secretary or equivalent	Fulfil the responsibilities of the Trust's Data Protection Officer
20	Chief Executive/ Company Secretary or equivalent	Ensure the Trust is registered with the Information Commissioner's Office, publishes information in line with the Freedom of Information Act requirements, and maintains and stores information in line with the Data Protection Act.
20.1.2	Director of Finance	Responsible for the accuracy and security of computerised financial data.
21.1.13	Director of HR & OD	Responsible for the accuracy and security of the payroll system.
21.1.14	Director of Finance	Fulfil the responsibilities of the Senior Information Risk Officer on behalf of the Trust.
22.1	~~Medical Director~~ Director of Finance	Authorise procurement of IT hardware, software or facility.
22.2	~~Medical~~	Ensure adequate arrangements for disaster recovery and

	~~Director~~ Director of Finance	business continuity.
22.4	Director of Finance	Ensure new computerised financial systems and amendments to current computerised financial systems are developed in a controlled manner and thoroughly tested prior to implementation.
23	Chief Executive	Responsible for records management including systems for record retention.
24.1.1	Chief Executive	Risk Management Framework
24.4	Company Secretary or equivalent	All insurance arrangements and liaison with NHS Resolution.
24.5.3	Company Secretary or equivalent	Authorise all spend on external legal advice.

10. Operational Scheme of Reservation and Delegation - Introduction

10.1 The Board delegates budgetary responsibility to the Chief Executive who in turn delegates to the Executive Directors.

10.2 The Trust has five Directors, (one of which is the Chief Executive), who are classified as *Executive Directors*. The Director of Human Resources & Organisational Development is a director of the Board, but has no voting rights on the Board. The officers are personally responsible to the Chief Executive for their directorate/business units' budgets delegated to them.

10.3 Within the Business Units there is a triumvirate of the Associate Medical Directors, Associate Directors of Operations and Heads of Nursing who are appointed to lead management within their Unit. Ultimate budgetary responsibility, however, remains with the respective Executive Directors.

10.4 Executive Directors can delegate management of specific budgets or elements of budgets to *Budget Managers* (i.e., Deputy Directors or Senior Managers) and these arrangements should be set out in a locally developed *Directorate Scheme of Reservation and Delegation*, which should be effectively maintained and reviewed on an annual basis.

10.5 The *Directorate Scheme of Reservation and Delegation* must be aligned to the *Operational Scheme of Reservation and Delegation* set out in 10.9.

10.6 By exception and in accordance with the locally developed *Directorate Scheme of Reservation and Delegation*, budget managers can delegate management of specific budgets or elements of budgets to *Delegated Budget Managers* (i.e., Department Managers). Budgets must NOT be delegated below this level.

10.7 *Authorised signatories* may be assigned. These are staff members assigned to sign against a budget manager's or delegated budget manager's budget but who are NOT

responsible for budget management.

10.8 Locally developed *Directorate Schemes of Delegation* developed within the parameters of this *Operational Scheme of Reservation and Delegation* must be approved by the Chief Executive.

10.9 Operational Scheme of Reservation and Delegation

Delegated Matter:	Authority Delegated to:
1. Management of Revenue Budgets	
a) Responsibility for maintaining compliance with budgetary allocation limits:	
○ For the totality of the Trust	Chief Executive
○ At Directorate level	Executive Director
○ At individual budget level (pay and non-pay)	Budget Manager or Delegated Budget Manager
○ For all central income budgets	Director of Finance
○ For all other areas	Director of Finance
b) Responsibility for transfers between budgets-non pay only	
○ Transfers between budgets within one area of responsibility	Budget Manager
○ Transfers between budgets beyond area of responsibility but within Directorates	Executive Director
○ Transfers between Directorate Allocations	Director of Finance and Chief Executive
2. Budget setting and monitoring	
○ Agreeing budgetary allocations including savings and efficiency targets	Trust Board
○ Monitoring of budgetary performance	Director of Finance
○ Performance delivery framework	Director of Finance escalated to Chief Executive
3. Maintenance/Operation of Bank Accounts	
○ Managing banking arrangements	Director of Finance
○ Operation of bank accounts	Assistant Director of Finance/Deputy Financial Accountant
○ Local commercial bank account. With (BACS and cheque payments)	Director of Finance (managed in accordance Bank mandate limits
○ Setting up direct debits/ Standing orders limits	Assistant Director of Finance/Deputy Financial Accountant (in accordance

	with Bank mandate)
○ Use of the corporate credit card (held by Director of Finance)	Assistant Director of Finance/Deputy Financial Accountant (subject to card limit)
4. Non-Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services	
a) Requisitions	
○ All requisitions (stock/non-stock) up to £499	Authorised budget signatory
○ All requisitions from £500 to £9,999	Budget Manager or Delegated Budget Manager
○ All requisitions from £10k to £49,999 ○	Executive Director
○ All requisitions from £50k to £499,999 total cost	Chief Executive or Director of Finance
○ Requisitions above £500,000 ** For operational purposes, the Director of Finance has a £10m approval limit on the finance system. However, approvals above the DoF limit of £500k are subject to Board approval.	Trust Board approval
b) Non-pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive or Director of Finance
c) Virements (budget transfers) To manage under and overspends within individual approved budgets, budget holders are permitted to "vire" between budgets based on the following agreement and authorisation	
○ Within a cost centre and budget type (non-pay)	ADO with Finance Business Partner
○ Between pay and non-pay	ADO and responsible Executive Director
○ Between cost centres within the Executive's Portfolio	ADO and responsible Executive Director
○ Between Executive Portfolios	Director of Finance and Chief Executive
d) Recurrent virements (within the same financial year)	
○ Within a cost centre and budget type (non-pay)	ADO and responsible Executive Director
○ All other Virements	Director of Finance and Chief Executive
e) Subsequent variations to contract:	

○ With a value not exceeding £99,999	Executive Director or Director of Finance
○ With a value exceeding £100k up to £0.5m per annum	Director of Finance and Chief Executive
d) Purchase order approval (including pharmacy)	
○ Up to £10,000	Purchasing officer/Senior Pharmacy Technicians
○ Up to £20,000	Senior Purchasing Officer/Deputy
○ Up to £50,000	Pharmacist Deputy Procurement Manager/Chief Pharmacist
○ Up to £100,000	Procurement Manager
○ Over £100,000	Director of Finance
f) Payments	
○ Calculation of payment values based on cash flow forecast	Assistant Director of Finance/Deputy Financial Accountant
○ Approval of payment runs	Assistant Director of Finance/Deputy Financial Accountant Payable Manager
5. Capital Schemes	
a) Approving the annual capital programme	Trust Board (within the Annual Financial Plan)
b) Variation to the total agreed capital programme	Trust Board (subject to compliance with the capital resource limit)
c) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Facilities Manager, Technical Services or ~~Deputy CEO/Director of Strategy~~ Director of Finance
d) Approval of new capital schemes in year	
○ Up to £100,000	Capital Investment Group and then Hospital Management Board
○ Between £100,000 and £250,000	Finance Performance & Investment Committee
○ Above £250,000	Trust Board
e) Variation in value of capital schemes	
○ Variations > 20% but less than £50,000	Capital Investment Group
○ Variations > 20% but less than £250,000	Finance Performance & Investment Committee
○ Variations > 20% and more than £250,000	Trust Board

f) Capital requisition approval limits	
○ Up to £100,000	Financial Accountant/Assistant Director of Finance
○ Up to £500,000	Chief Executive/Director of Finance
○ Over £500,000	Trust Board
g) Estates stage payment certificates	
○ Up to £100,000	Project Scheme Manager
○ Up to £500,000	Chief Executive/Director of Finance
○ Over £500,000	Trust Board
h) Capital contingency authorisation	
○ Up to £50,000	Director of Finance
○ Up to £100,000	Capital Investment Group
○ Up to £250,000	Finance, Performance & Investment Committee
○ Over £250,000	Trust Board
i) Private Finance Initiative (PFI)	
○ Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.	Director of Finance
○ Proposal to use PFI	Trust Board
6. Authority to Obtain Quotation, Tendering and Contract Procedures	
a) Obtaining informal quotations for goods/ services £5,000 - £25,000	Budget Manager
b) Obtaining competitive tenders for goods/ services £25,001 to EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through Contracts Finder or obtained via an accessible framework.*	Executive Director via Procurement
c) Obtaining competitive tenders over EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through OJEU and Contracts Finder or obtained via an accessible framework.*	Executive Director via Procurement
d) Waivering of quotations and tenders subject to SFI 16.8:	
○ Up to £74,999	Director of Finance
○ £75k up to EU thresholds	Director of Finance and Chief

	Executive
e) Opening electronic and manual/hard tenders	Deputy Director of Finance or Director of Finance and Company Secretary or equivalent
f) Balance sheet	
• Approve payment of PAYE, National Insurance, Superannuation.	
○ Authorisation of NHS Shared Business Services	Assistant Director of Finance/ Deputy Financial Accountant
○ Reconciliation of payments for PAYE, National Insurance and superannuation. Value limited to BACS threshold of £7m	Assistant Director of Finance/ Deputy Financial Accountant
○ Approve payment of payroll pay-overs	Assistant Director of Finance/Deputy Financial Accountant
• Authorisation of payments for court orders, Union fees, Medicash and other payroll deductions. Limit for each individual payover is up to £20,000.	
○ Approve payment of Balance sheet items	Assistant Director of Finance/ Deputy Financial Accountant
Up to £200,000. Payment limit applies to Alliance Healthcare monthly agreement, weekly Liaison Staff flow payroll service and monthly Disbursement service	
g) Approve payment of salary advances	
Up to £10,000	Assistant Director of Finance/Deputy Financial Accountant
7. Charitable Fund approvals	
○ Up to £5,000	Director of Finance
○ Up to £20,000	Chair of Charitable Fund Committee
○ Over £20,000	Trust Board acting as Corporate Trustee
8. Setting of Fees and Charges	
a) Price of NHS Contracts with commissioners	Director of Finance
b) External fees, private patient, overseas visitors, income generation and other patient related services	Director of Finance
c) Fees for items of a sensitive nature	Chief Executive
9. Engagement of personnel not employed by the Trust	

a) Non-Medical Consultancy Staff	Executive Director in line with delegated financial limits
b) Engagement of Trust Solicitors	Company Secretary or equivalent [in their absence, Chief Executive, Director of Finance, Director of Nursing, Midwifery & Therapies and Director of Human Resources & Organisational Development]
c) Engaging of staff not on Trust establishment	Executive Director with Director of Finance and current regulator
10. Agreements / Licenses	
a) Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff	Director of Finance
b) Extensions to existing property and equipment leases	Director of Finance
c) Establishing or terminating leases with annual rental up to £199,999	Director of Finance
d) Establishing or terminating leases with annual value between £200k and £500k	Chief Executive
e) Granting of use of Trust property under license	Director of Finance
11. Condemnations and Disposals	
Items (excluding land and buildings) that are obsolete, redundant, irreparable or cannot be cost effectively repaired:	
a) With current/estimated value <£100 as determined by the budget holder	Delegated budget holder
b) with current/estimated value >£100 up to £4,999 as determined by the budget holder	Executive Director
c) with current/estimated value >£5k as determined by the budget holder	Director of Finance
d) disposal of mechanical and engineering plant and all equipment (subject to estimated income of less than £5k per sale) as determined by the budget holder	Director of Finance
e) disposal of mechanical and engineering plant and all equipment (subject to estimated income exceeding £5k per sale) as determined by budget holder	Director of Finance
12. Losses, Write-offs, and Compensations	
a) Losses (inc. cash) due to theft, fraud, overpayment, and others up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance

○ £5k to £49,999	Chief Executive or Director of Finance
b) Fruitless payments (including abandoned capital schemes) up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
c) All bad debts and claims abandoned, private patients, overseas visitors and other up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, arson, theft) or other up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
e) Compensation payments made under legal obligation:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
f) Extra contractual payments to contractors up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
Ex-gratia payments	
g) Staff and patients for loss of personal effects:	
○ Less than £999	Executive Director
○ £1,000 to £4,999	Director of Finance or Deputy Director of Finance
○ £5,000 to £49,999	Chief Executive or Director of Finance
h) Other:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ More than £5,000	Chief Executive or Director of

	Finance
13. Reporting of Incidents to the Police	
a) Fraud	Company Secretary or equivalent /Director of Finance/
b) Other	Executive Directors
14. Petty Cash Disbursements (through central cashiers' office at each site)	
○ Expenditure up to £50	Budget Manager or Delegated Budget Manager
15. Implementation of Internal and External Audit Recommendations	Director of Finance/ Company Secretary or equivalent and Lead Executive, monitored by the Audit Committee
16. Maintenance and Update of Trust Financial Procedures	Director of Finance
17. Investment of Funds (including charitable and endowment funds)	
a) Exchequer	Director of Finance
b) Funds held on Trust	Charitable Trustees (Board of Directors
18. External Borrowing	
a) Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Director of Finance
b) Application for draw down of Public Dividend Capital, overdrafts, DH loans and other forms of External borrowing	Trust Board
19. Personnel & Pay	
a) Authority to fill funded post to the establishment with permanent staff.	Budget Manager or Delegated Budget Manager for Band 5 nurses- all other posts must have Executive Directors' approval via PAG
b) Authority to alter funded establishment:	
○ Additional staff to the agreed establishment with specifically allocated finance	Executive Director
○ Additional staff to the agreed establishment without specifically allocated finance	Executive Director
c) Additional increments:	
○ The granting of additional increments to staff within budget where acting up	Executive Director
○ The granting of additional increments to staff within budget on permanent basis	Executive Director, on advice from HR and authorisation from Finance

d) Upgrading and re-grading	
○ Approval of market supplements and other variations to terms and conditions	~~Associate Director of HR~~ Director of HR and OD
e) Establishments:	
○ Approval of consultants' posts (medical/nursing and other clinical)	Appropriate Executive Director
f) Pay:	
○ Authority to complete standing data forms effecting pay, new starters, variations, and leavers	Budget Manager or Delegated Budget Manager
○ Authority to authorise overtime	Budget Manager or Delegated Budget Manager
○ Authority to authorise travel and subsistence expenditure	Budget Manager or Delegated Budget Manager
○ Authority to agree local pay uplifts including allowances that form part of pay	~~Associate Director of HR~~ Director of HR and OD
g) Redundancy/early retirement:	
○ Chief Executive or Executive Director	Remuneration Committee
○ Other member of staff	Chief Executive and Director of HR
20. Authorisation of New Drugs	
Drugs approved by Medicines and Therapeutic Committee	Executive Director and Associate Medical Directors
b) Research/clinical trials:	
○ Ethical approval	~~Medicines and Therapeutics Committee~~ Drugs and Therapeutics Group
○ Funding	Executive Director and Associate Medical Directors
21. Authorisation of Sponsorship Deals	Company Secretary or equivalent [In accordance with Standards of Business Conduct and Managing Conflict of Interest Policy]
22. Authorisation of Research Projects	Director of Nursing, Midwifery & Therapies
23. Authorisation of Clinical Trials	Medical Director
24. Governance / Risk Management	
a) Overall responsibility for ensuring that appropriate and effective governance / risk management arrangements, policies, and procedures and meeting structures, including the provision of advice and support to the	Chief Executive

Trust	
b) Responsibility for ensuring that governance is 'owned by all' and for the identification of leads to co-ordinate governance activities at a local level	Company Secretary or equivalent All Executive Directors/ Associate Medical Directors/ Heads of Nursing and Associate Directors of Operations
25. Insurance Policies	
a) Medico-legal	Company Secretary or equivalent
b) All other insurance	Company Secretary or equivalent
26. Management of Incidents, Serious Untoward Incidents, Complaints, Concerns and Claims	
Incidents	
a) Overall responsibility for ensuring that systems and processes are in place to report and respond to incidents and SUIs	Director of Nursing, Midwifery & Therapies
b) Responsibility for ensuring that incidents and SUIs are investigated thoroughly and in a timely manner and that appropriate remedial action is taken / lessons learnt are shared	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Complaints / Concerns	
a) Overall responsibility for ensuring that all complaints and concerns are dealt with effectively	Director of Nursing, Midwifery & Therapies
b) Responsibility for ensuring complaints relating to a Directorate / Group are investigated thoroughly and within agreed timescales and that appropriate remedial action is taken / lessons learnt are shared	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Claims	
a) Responsibility for ensuring that claims are dealt with effectively and within accordance with agreed procedures and timescales	Company Secretary or equivalent
b) Responsibility for ensuring the provision of timely information to enable the Trust to respond effectively to claims and for ensuring that appropriate remedial action is taken / lessons learnt are shared	Company Secretary or equivalent /All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
27. Media Relations	
a) Within working hours	Head of Communications and Marketing
b) Out of hours	On-Call Director / Head of Communications and Marketing

28. Infectious Diseases and Notifiable Outbreaks	Medical Director or Control of Infection Doctor
29. Facilities for staff not employed by the Trust to gain practice experience and/or to provide services	
a) Clinical staff	Director of Nursing, Midwifery & Therapies or Medical Director
b) Other staff	Appropriate Executive Director
30. Review of Fire Precautions (Nominated Fire Officer)	Director of Finance
31. Review of Medicines Inspectorate regulations	Chief Pharmacist
32. Review of compliance with environmental regulations	Director of Finance
33. Information Governance	Senior Information Risk Officer /Data Protection Officer (DPO)
34. Declarations of Interest Register, including Gifts and Hospitality and Sponsorships	Company Secretary or equivalent
35. Attestation of Sealings in accordance with the Standing Orders, including the keeping of the Register of Sealings	Company Secretary or equivalent
36. Retention of Records	
a) clinical	Chief Operating Officer
b) financial	Director of Finance
c) other	Executive Directors and Company Secretary or equivalent
d) Retention and Management of Policy	Company Secretary or equivalent
37. Caldicott Guardian	Medical Director
38. Audit and Quality, including implementation of NICE guidance	Director of Nursing, Midwifery & Therapies
39. Use of borrowing as financing mechanism	Trust Board
40. Intellectual Property	
a) Approval of license agreements	Chief Executive and Director of Finance
b) Material changes to IP policy	Trust Board

c) Departure from inventor reward in IP policy	Executive Team
41. Compliance with the requirements of the Civil Contingencies Act	Trust Board
42. Approval of creating, selling, or ceasing joint ventures	Trust Board
43. Director of Infection Prevention and Control	Medical Director

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 DECEMBER 2020**
Agenda Item	**TB201/20b**	**FOI Exempt**	**NO**
Report Title	**CORPORATE GOVERNANCE STRUCTURE**		
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 present the updated Governance Structures following review.

Executive Summary

In line with the S.5.4.10 of the Scheme of Reservation and Delegation, the Trust's Governance Structure have been updated to ensure they continue to reflect processes and procedures which facilitate the effective discharge of the Trust's business.

Notable changes to bring to the Board's attention are as follows:

a) Establishment of the Charitable Funds Group which will report into Charitable Funds Committee
b) The introduction of the Performance Improvement Development and Assurance Board (PIDA) Board which will align to the Trust's Single Assurance Framework
c) The inclusion of the Shaping Care Together which reports to Board and also provides an update to the Hospital Management Board
d) Changing of reporting lines for the Risk and Compliance Group, Chaired by the CEO, which will now report to the Quality and Safety Committee. The Terms of Reference of the Group will be amended to reflect this change.

Once adopted, all Committee Terms of Reference will be updated to reflect the new Governance Structures. The Board is therefore requested to delegate approval of the updated Committee Terms of Reference to the respective committees.

Recommendations

The Board is asked to **receive** and **approve** the Corporate Governance Structures.

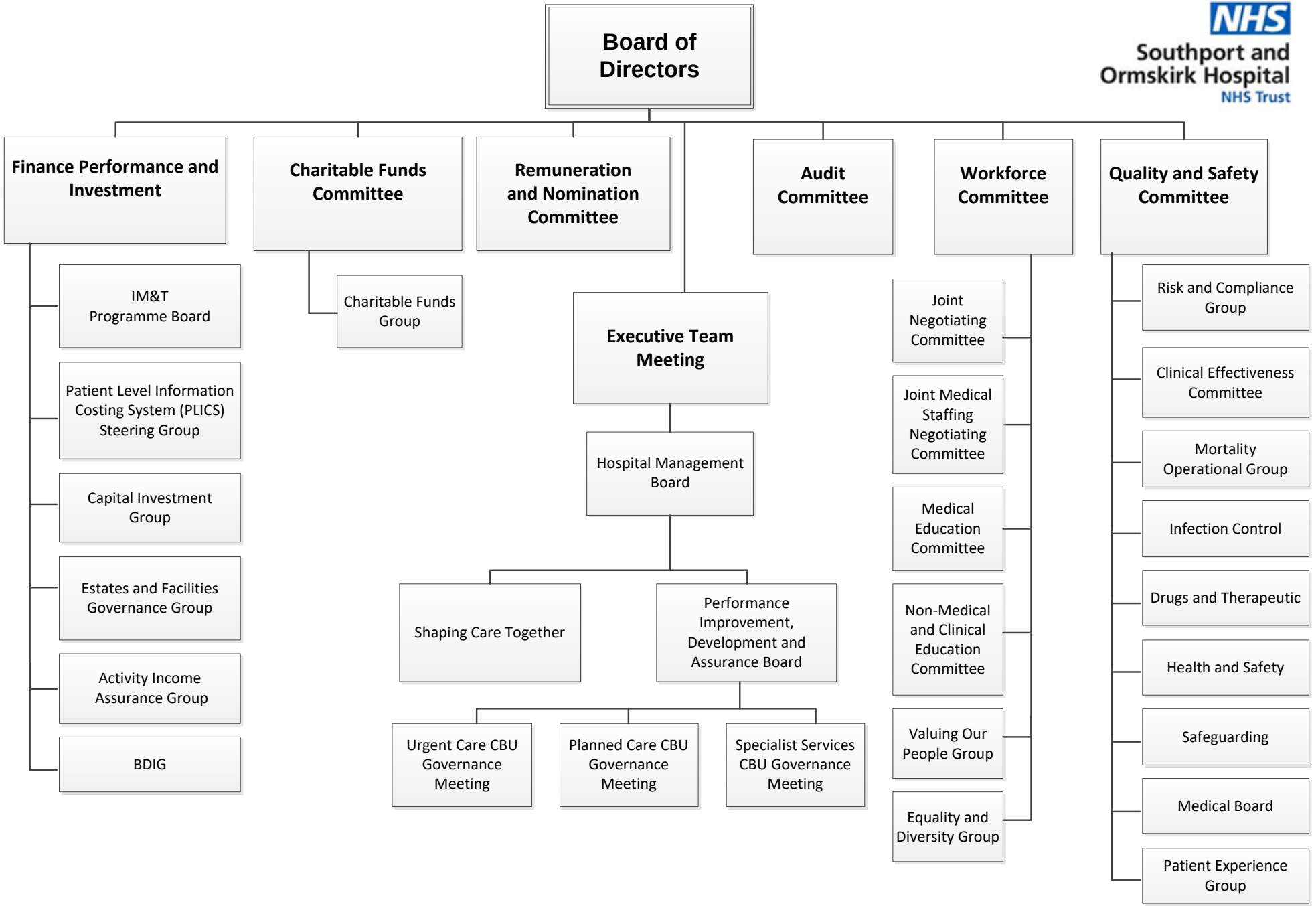
Previously Considered By:

☐ **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


Board of Directors
Finance Performance and Investment
Charitable Funds Committee
Remuneration and Nomination Committee
Audit Committee
Workforce Committee
Quality and Safety Committee
IM&T Programme Board
Patient Level Information Costing System (PLICS) Steering Group
Capital Investment Group
Estates and Facilities Governance Group
Activity Income Assurance Group
BDIG
Charitable Funds Group
Executive Team Meeting
Hospital Management Board
Shaping Care Together
Performance Improvement, Development and Assurance Board
Urgent Care CBU Governance Meeting
Planned Care CBU Governance Meeting
Specialist Services CBU Governance Meeting
Joint Negotiating Committee
Joint Medical Staffing Negotiating Committee
Medical Education Committee
Non-Medical and Clinical Education Committee
Valuing Our People Group
Equality and Diversity Group
Risk and Compliance Group
Clinical Effectiveness Committee
Mortality Operational Group
Infection Control
Drugs and Therapeutic
Health and Safety
Safeguarding
Medical Board
Patient Experience Group