NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA
BOARD OF DIRECTORS' MEETING

To be held at 1000 on Wednesday 03 February 2021

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***1000***
TB001/21 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB002/21 (D)	**Declaration of Directors' Interests concerning agenda items** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB003/21 (D)	**Minutes of the previous meeting** a) Meeting held on 02 December 2020 *Purpose: To **approve** the minutes of the previous meetings*	No	*Chair*	10 mins
TB004/21 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
STRATEGIC CONTEXT				**1010**
TB005/21 (V)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*5 mins*
TB006/21 (D)	**Chief Executive's Report** *Purpose: To **receive** an update on key issues from the CEO*	*No*	*CEO*	*10 mins*
COVID-19 UPDATE				**1025**
TB007/21 (V) (D)	**Covid-19 Update** a) Covid-19 Update b) Infection Prevention Control Assurance Framework *Purpose: To **receive** the Covid-19 Update*	*No*	*Execs DoN*	*15 mins*
INTEGRATED PERFORMANCE REPORTS				**1040**

TB008/21 (D)	**Integrated Performance Report (IPR) Summary** a) Activity Summary b) Head of Information Summary c) IPR Executive Summary *Purpose: To **receive** the IPR for assurance.*	*No*	*CEO / DCEO*	5 mins
QUALITY & SAFETY				**1045**
TB009/21 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report (25 January 2021) b) Committee AAA Highlight Report (14 December 2020) c) Quality and Safety Performance Report *Purpose: To **receive** the reports for information and assurance*	*No*	*Cttee Chair DoN/MD*	10 mins
TB010/21	**CQC Progress Report** *Purpose: To **note** the CQC Progress Reports*	*No*	*DoN*	5 mins
OPERATIONS AND FINANCE				**1100**
TB011/21 (D)	**Finance, Performance and Investment (FPI) Reports** a) Committee AAA Highlight Report b) Operational Performance Report *c)* Financial Performance Report *d)* Director of Finance Report *Purpose: To **receive** the reports for information and assurance*	*No*	*Cttee Chair IDoF*	15 mins
WORKFORCE				**1115**
TB012/21 (D)	**Workforce Committee** a) Committee AAA Highlight Report *b)* Workforce Performance Report *Purpose: To **receive** the reports for information and assurance.*	*No*	*Cttee Chair DoHR*	10 mins
TB013/21	**Workforce Reports** *a)* Our People Plan – Workforce and OD Strategy b) Equality, Diversity and Inclusion Annual Report *Purpose: To **note** the reports for information*	*No*	*DoHR*	5 mins
RISK AND GOVERNANCE				**1130**
TB014/21 (D)	**Audit Committee** a) Committee AAA Highlight Report *Purpose: To **receive** the report*	*No*	*Ctee Chair*	*5 mins*

TB015/21 (D)	**Board Assurance Framework** *Purpose: To **receive** the updated Board Assurance Framework*	*No*	*ADCG*	*10 mins*
TB016/21 (D)	**Corporate Risk Register** *Purpose: To **receive** the Corporate Risk Register*	*No*	*DoN*	*5 mins*
ITEMS FOR INFORMATION				**1150**
CONCLUDING BUSINESS				**1150**
TB018/21 (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*
TB019/21 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*		*Chair*	*3 mins*
TB020/21 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	*2mins*
	Date and time of next meeting: **0900, Wednesday 03 March 2021**			***1200 close***
RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC				
	The Trust Board resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	**Chair**		

Chair: Neil Masom

NHS Southport and Ormskirk Hospital NHS Trust

Register of Interests Declared by the Board of Directors as at 01 February 2021

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	Loyalty Interests	Other	Date of review and update
ARMSTRONG-CHILD Mrs Trish	Chief Executive Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	25 Jan 21
BIRRELL, Mr Jim	Non-Executive Director	Nil	Nil	Nil	Lay Member of Cheshire & Merseyside Sub-Committee of Advisory Committee on Clinical Excellence Awards	Nil	Nil	Nil	07 Jan 21
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	20 Jan 21
CHRISTIAN, Mr Steven	Deputy CEO & Chief Operating Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	27 Jan 21
GIBSON, Mrs Pauline	Non-Executive Director Designate	Nil	Director: Excel Coaching and Consultancy.	Nil	Nil	Nil	Nil	Nil	28 Jan 21

NHS Southport and Ormskirk Hospital NHS Trust

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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 NHS Professionals- Public Health England 2020 to date	Nil		11 Jan 21
GREGORY, Mr Bill	Interim Director of Finance	Healthcare Business Partners Limited ND – Liaison Group	Shareholder – Healthcare Business Partners Ltd	Shareholder and person with significant control – Healthcare Business Partners Ltd	Trustee – Healthcare Financial Management Association (HFMA)	Lay member of Finance and General Purpose Cttee University of Lancaster			4 Jan 21
HANKIN Dr Terence	Medical Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil	27 Jan 21
KATEMA Mrs Sharon	Associate Director of Corporate Governance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	26 Jan 21
LEES Ms Bridget	Director of Nursing, Midwifery and Governance	Nil	Nil	Nil	Nil	Nil	Spouse employed by Trust as Pharmacy Technician	Nil	27 Jan 21

NHS Southport and Ormskirk Hospital NHS Trust

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MASOM Mr Neil	Chairman & Non- Executive Director	JSSH Ltd NDLM Ltd	Nil	Nil	Seashell Trust	Nil	Nil	Nil	27 Jan 21
POLLARD Mr Graham	Non-Executive Director	Nil	Nil	Nil	Nil	Trustee at Alder Hey Children's Kidney fund	Nil	Employed by the University of Liverpool	27 Apr 20
ROYDS, Mrs Jane	Director of Human Resources& Organisational Development	Nil	Nil	Nil	Nil	Nil	Nil	Vice Chair of Governors, Farnborough Road Junior School, Southport	28 Jan 21
SHANAHAN, Mr Steve	Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Trustee – Age Concern	5 Feb 20
SINGH, Mr Gurpreet	Non-Executive Director	Nil	GS Urology Ltd: providing practice & GMC work	Nil	Private practice at Ramsay Health Trustee at BAUS (British Association of Urological Surgeons) Trustee of the Southport and District Medical Education Centre Fund		Nil	Honorary Professorship with Bolton University	28 Jan 21

Draft Minutes of the Board of Directors' Meeting
Held on Microsoft Teams
Wednesday 02 December 2020
(Subject to the approval of the Board on 03 February 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 Catherine Boyle	Consultant Midwife *(Item TB197/20)*
Mr Tony Ellis	Communications and Marketing Manager
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Uma Karthikeyan	Clinical Director Obstetrics & Gynaecology *(Item TB197/20)*
Mrs Joanna Stark	Interim Deputy Chief Operating Officer *(Item TB197/20)*
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		

TB186/20 Chair's Welcome and Note of Apologies

Mr Masom welcomed all in attendance advising that the date was of great significance as it marked a year since Mrs Armstrong-Child joined the Trust and marked two years since he joined the Trust. He thanked Mrs Armstrong-Child on behalf of the Board for her contribution over the previous year.

It was noted that Dr Bussin from St Helens and Knowsley Hospital NHS Trust was observing the meeting as part of his leadership development.

The Board noted apologies for absence from Mr Shanahan.

TB187/20 Declaration of interests

There were no declarations of interests in relation to the agenda items.

RESOLVED:
The Register of Interests was **approved.**

TB188/20 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 04 November 2020 and approved them as a correct and accurate record of proceedings subject to the following amendment:

- Board Attendance (page 24) to be amended to reflect Mr Shanahan's apologies.

RESOLVED:
The Board **approved** the minutes from the meeting held on 04 November 2020.

TB189/20 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

TB190/20 Patient's Story

Ms Lees introduced the patient story regarding Mr Fraser's video which provided an insight into a patient's experience, treatment and recovery following admission within the hospital during the pandemic.

Mr Fraser, a 60 year old gentleman, was admitted to Southport Hospital with Covid-19 symptoms and subsequently tested positive for Covid-19. He relayed his admiration for the staff that had looked after him throughout his treatment in Critical Care and subsequent step down to a ward area prior to discharge. In terms of areas of improvement, Mr Fraser highlighted that, whilst he understood the need for patients to communicate on mobile phones, consideration should be given to the impact on other patients especially at night time. Mr Fraser's predicted discharge time had to be changed due to timings of medications and a stair assessment. This resulted in some disappointment for Mr Fraser as he had to stay an additional night in hospital.

All members were in agreement that this was a very poignant story and Mr Masom thanked Mr Fraser for sharing his story.

Mrs Armstrong-Child commented that patients that had recovered from Covid-19 would require significant emotional and physical long term support.

In addition to the patient story, the Critical Care Team recorded a video tour showcasing a patients' journey throughout the department. The Board commended the team for continually exploring innovative ways in which they

could support families during the pandemic which had culminated in the Unit's winning the Nursing Times Award.

RESOLVED:
The Board **received** the patient story.

STRATEGIC CONTEXT

TB191/20 Chair's Report

Mr Masom presented the report detailing activities undertaken since the previous meeting. In acknowledging the increase in the number of Covid-19 admissions, he expressed gratitude to all staff for the continued hard work during the challenging period.

The following key points were noted from the report:

- The fortnightly Cheshire and Mersey (C&M) Chairs' meetings have continued to take place during the pandemic and the latest meeting focused on increased staff testing, vaccinations and mental health.
- Shaping Care Together had moved into the communication and engagement phase with stakeholders.
- The Trust's Annual Flu Campaign had received fantastic support from all staff and 91 % staff had been vaccinated by the end of November.

Mr Masom thanked members of the public for their contribution to the Southport and Ormskirk Hospital Charity. A subgroup had been set up to ensure that the proper governance was in place to ensure that funds were raised and spent appropriately.

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

TB192/20 Chief Executive's Report

Mrs Armstrong-Child presented her report which provided an overview of activities that had occurred within the Trust. She drew attention to the following key points from the report:

- Recipients of awards including
    - External recognition for members of staff
    - Thanks a bunch awards
    - So Proud awards

The virtual Time to Shine Awards would be broadcast online on Thursday 17 December at 18.30. Holding the awards in this format would make it special for staff as they could all share the experience with friends and family who were not normally involved in proceedings.

The Trust was now part of the NHS 111 service which could provide a booked time slot for attendance at Emergency Department.

The automatic number plate recognition (ANPR) car parking system was now in place and would make parking easier across both sites. In addition, Blue Badge holders would be able to park for free at the Southport and Ormskirk hospital sites from 01 December 2020 when car parking charges were reinstated. Staff would continue to park for free until further notice.

Temporary staff and students would be included in the rollout of lateral flow kits that would offer asymptomatic screening.

Mrs Armstrong-Child advised that Care Clinics had been set up to assist with the identification of themes and impact on patients following the increase in the number of complaints which had seemingly been compounded by the visiting restrictions.

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

COVID-19 UPDATE

TB193/20 Covid-19 Update

a) Covid-19 Update

Mr Christian presented the Covid-19 Update which provided an overview of the impact of Covid-19. The Trust had been caring for patients via three different work streams using the red, amber and green principle.

The growth rate of the first wave had been twice that experienced during the second wave; however, the second wave had been of a longer duration but a reduction in the rate of community infection had been noted.

A forecast, based on the scenario of a national lock down, had shown a significant risk of a third wave by mid-January. This would coincide with the predicated surge in respiratory illness, slips, trips and falls and a safer start campaign had been planned to support this anticipated surge.

Trusts within the system were reporting a 20% occupancy rate for Covid-19 positive patients. Whilst there were challenges in achieving the 4hour ED Standard, ED performance had increased compared with the same period in 2019. Furthermore, there had been no corridor care since March 2020 and ambulance handover times remained within 30 minutes. Overall ED attendance had decreased at SDGH whilst there had been a 5% increase in the number major admissions.

The proactive approach to Infection Prevention and Control (IPC) measures had resulted in the decision to close wards to admissions when necessary.

There had been an increased focus on patient discharge and collaborative work with system partners around the reconfiguration of enhanced intermediate out of hospital care to increase services.

Following the mandate to postpone all non-urgent elective work for three months during the first wave, the Trust had not managed to perform 800 procedures. This resultant backlog had been diligently managed through an effective restoration plan that had been in place since September. However, the recovery efforts had been impeded by patients' inability to self-isolate before a procedure as well as the need to comply with PHE requirements with respect to donning and doffing requirements.

Mr Christian advised that the Trust had been able to manage a full directory of services despite an increase in workforce absence during both the first and second waves. It was noted, that at 12%, the medical domain vacancy rate meant there had been an increase in reliance on temporary workforce. The Board acknowledged the efforts by the Executive Team to implement an incentive programme that would provide a sustainable workforce to support clinical services during the winter months.

Plans for the rollout of the Covid-19 vaccine were underway with oversight and delivery of the programme being overseen by the Project Management Office (PMO). Regular updates on logistical planning based on the guiding principles received from the national teams, were presented at Gold Command.

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

b) Infection, Prevention and Control Assurance Framework
Ms Lees presented the Infection, Prevention and Control (IPC) Assurance Framework report which provided the Board with an update of the Trust's position against the measures contained within the IPC Assurance Framework.

In response to Mr Singh's question around the low rate of asymptotic staff following the rollout of the lateral flow testing and nosocomial infections, Ms Lees advised that the increase in nosocomial infections could be related to high occupancy within the hospital.

RESOLVED
The Board **received** the IPC Assurance Framework update

INTEGRATED PERFORMANCE

TB194/20 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.

RESOLVED:
The Board **received** the IPR Summary Report

QUALITY AND SAFETY

TB195/20 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 23 November 2020 advising that the Alerts included in the report had already been addressed by the Executive Team and feedback had been received.

The Committee had noted the decrease in the number of complaints received due to the introduction of the Patient Advisory and Liaison Service (PALs) which indicated a responsive organisation.

b) Quality and Safety Performance Report

Ms Lees presented the Quality and Safety Performance report advising that:

- Venous Thrombo-Embolism (VTE) continued to show negative variation despite achieving plan in October, work to provide assurance was ongoing
- 90% safe staffing rate had not been achieved in month but the recently introduced incentive scheme had shown a 6% increase in fill rate.
- Complaint Clinics have been introduced to allow the Trust to respond quickly to complaints received.

In his update, Dr Hankin highlighted that he would be meeting with the Orthopaedic Clinical Director to discuss performance around fractured neck of femur and agree a plan for winter. He outlined that the decline in Sepsis performance was down to incorrect recording of antibiotics administration time adding that this was being reviewed and monitored.

Patient Experience Strategy

Ms Lees presented the Patient Experience Strategy and Patient Experience Quality Improvement plan which had been developed and had been

endorsed for approval at the Quality and Safety Committee. It was noted that the inclusion of the Shaping Care Together and the Workforce Strategy, would ensure that the right culture and patient strategy was reflected in the plan.

RESOLVED:
The Board **received** the Quality and Safety reports and **approved** the Patient Experience Strategy.

TB196/20 **Quality Accounts**

Ms Lees presented the draft Quality Account following review and endorsement at both the Audit and Quality and Safety Committees. Noting that the reports were still in draft, it was agreed that the committee chairs would need to be advised of any additional amendments. It was agreed that comments from Mr Birrell regarding the number of items that still required checking would be considered outside of the meeting.

RESOLVED:
The Board **approved** the draft Quality Accounts

TB197/20 **Maternity 6 Monthly Update**

(Mrs Boyle, Mrs Karthikeyan and Mrs Stark joined the meeting)

Mrs Catherine Boyle and Mrs Uma Karthikeyan delivered the Maternity Services update which focused on:

- Progress of 'Better Births' regarding delivery of Continuity of Carer
- Progress to achieving 'Saving Babies Lives'
- Perinatal Mortality Rate
- CNST Maternity Incentive Scheme
- Workforce
- Update on the Care Quality Commission

The Board was advised that the improvement plan for Saving Babies Lives had made good progress and was nearing completion. However, the following challenges had been identified and were being addressed:

- An upgrade to the Trust Information system was due to commence to ensure conformity with the MSDS submission requirements
- System C upgrading delays had impacted the implementation of GROW interface
- Delays in completion of audits to demonstrate compliance to guidelines due to competing priorities were now being actioned.

With regards to the Perinatal Mortality rate, the Serious Incident Review Group (SIRG) had been reviewing the increase in still births and increase in neonatal admissions where intrapartum management affected their outcome.

Whilst the home birth service had been temporarily suspended during the first wave of Covid-19 due to staff sickness and concerns around NWAS support during the pandemic, the service had been continuing to operate throughout the second wave.

The key priorities for the Maternity Service over the next six months included:

- Completion of the review into unexpected neonatal admissions and embedding of lessons learnt
- Working towards completion of the 10 CNST safety actions
- Implementation of the continuity of carer model
- Establishing a patient experience strategy and staff recognition approach for the CBU

Mrs Armstrong-Child commented that the visiting restrictions which were in place during Covid-19 had caused distress as birthing partners had not been able to attend all scans. However, this was being reviewed in line with national guidance and a resolution would be available shortly

RESOLVED:
The Board **received** the presentation for assurance

(Mrs Boyle, Mrs Karthikeyan and Mrs Stark left the meeting)

TB198/20 Medical Director's Reports

a) Learning from Deaths Quarterly Reports

Dr Hankin presented the Learning from Deaths Quarterly Reports which provided an update on the Trust's mortality and learning from deaths for Q.1 and Q.2. The following key points were noted:

- a detailed update around the Summary Hospital-level Mortality Indicator (SHMI) would be presented at the next Quality and Safety meeting for review.
- Work to examine the diagnosis group of 'fluid and electrolyte disorders' and deaths after discharge was ongoing. SHMI, which included these deaths, was within expected norms but above 100 and this was likely due to Covid-19 exclusions.
- considerable progress over the last 18 months had been made resulting in the Trust moving from the third worst to the 3rd best in the region.

Dr Hankin commended the Chief Operating Officer and his team for the approach to stopping corridor care since March and the introduction of the Emergency Village had played a part in the ongoing improvement in this area.

b) Medical Vacancies Report

Dr Hankin presented the Medical Vacancies Report which provided an update on the current position on Medical vacancies as well as the challenges going forward. The impact of the recruitment crisis had been felt most acutely in Medicine and Anaesthesia services and the recent Royal College of Physicians (RCP) census findings had illuminated the crisis in the medical workforce. The report highlighted that the situation would worsen over time and a solution would need to be found. This would be discussed at Strategy meeting scheduled for 06 January 2020.

c) Medical Appraisal and Revalidation Report

Dr Hankin presented the Medical Appraisal and Revalidation Report which provided assurance that the appropriate processes were in place to ensure that the Trust was compliant with its legal obligations.

It was noted that Southport and Ormskirk NHS Trust had been recognised as having the best organised and administrated system in the region.

RESOLVED:

The Board **approved** the Medical Director's Reports.

OPERATIONS AND FINANCE

TB199/20 Finance, Performance and Investment (FPI)

a) Committee AAA Highlight Report

Mr Pollard presented the key issues highlight report from the Committee meeting held on 23 November. He informed the Board that the following alert had been raised:

- The substantial funding gap in the North West region in months 7 to 12 of the financial year. Whilst the position would be reassessed at regional level in December, there was uncertainty going into the fourth quarter as the Trust was waiting for confirmation of funding allocation for this period. Assurance had now been received around the delivery of out of hospital schemes that had been included in the system winter plan.

b) Operational Performance Report

Mr Christian presented the Operational Performance Report which provided a summary of operational activity for October 2020 and highlighted the following:

- Despite the closure of the dedicated Stroke ward due to Covid-19, all patients had been seen through clinically designed mitigated pathways.
- The decline in compliance against the 4hour ED Standard had not affected the improvement in key performance indicators (KPI) within this report.
- The FP&I Committee continued to monitor compliance against Referral to Treatment (RTT) standard following an increase in the three month deferment backlog waiting lists

c) Financial Performance Report

Mrs Bottomley presented the Financial Performance report advising that:

- the Trust had achieved a surplus position against the forecast deficit.
- Confirmation of the funding envelope for the second half of the year had not been received. However, the Trust had been asked to submit a revised forecast based on month 7 only.
- Agency and bank spend has remained high despite the reduction in spend from the previous month.
- The capital spend had been re-assessed and it was anticipated that the capital spend allocation would be spent in full before the end of the financial year following reassessment.

Mr Masom advised the meeting that at a recent System Management Board meeting the lead officer for the Sefton CCG had commented favourably on the financial management within Trust.

RESOLVED:

The Board **received** the reports for information and assurance

WORKFORCE

TB200/20 Workforce Reports

a) Committee AAA Highlight Report

Mrs Gibson presented the highlight report from the Committee meeting held on 24 November 2020 and highlighted the following:

- There had been an increase in sickness absence including sickness due to non-work related stress. Health and Wellbeing (HWB) were working with staff to provide support where necessary.
- The rate of staff turnover had shown an improving trajectory for the month.
- There had been an improvement in the relationship between the Trust and NHSP and this had impacted positively on fill rates. The Trust would be expanding its bank to include Admin and Clerical services.

b) Workforce Performance Report

Mrs Royds presented the Workforce Performance Report and advised that, despite the reduction in Bank and Agency spend; it would be difficult to see a significant improvement over the remainder of the financial year due to the impact of Covid-19 on sickness levels.

RESOLVED:

The Board **received** the reports for information and assurance

CORPORATE GOVERNANCE

TB201/20 Corporate Governance Reports

a) Scheme of Reservation and Delegation

Mrs Katema presented the updated Scheme of Reservations and Delegation following review. The Board reviewed the SORD and agreed with proposed amendments in relation to S.5.10.3 and s.10.9. Mr Birrell advised that s.19b should not be included outside the Trust Board remit as changes in establishment could not be agreed without the business case process being followed. It was agreed that all Board members should be able to easily access the Corporate Governance documents.

RESOLVED:

The Board **approved** the Scheme of Delegation and Reservation

b) Corporate Governance Structures

Mrs Katema presented the updated Governance structures advising that the schematic had been reviewed and the following amendments had been made:

- Risk and Compliance Group would be moved from Audit Committee so it reported to Quality and Safety Committee.
- The structure now included the refreshed and newly created Performance Improvement Development and Assurance (PIDA) boards as well as the Shaping Care Together programme.

Following a concern regarding accountability of the Shaping Care Together Programme, it had been agreed that the Board was not directly accountable for the programme but would be able to keep track of progress through Board Assurance Framework Strategic Objective 06. It was agreed that the membership of the subcommittees would be reviewed to ensure that meetings were in line with agreed Terms of Reference.

RESOLVED:

The Board **approved** the Corporate Governance Structure

Southport and Ormskirk Hospital NHS Trust

ITEMS FOR INFORMATION

TB202/20 Committee Minutes

The minutes of the following Committees were noted:

a) Finance, Performance, and Investment Committee
b) Quality and Safety Committee
c) Workforce Committee

RESOLVED:
The Board **noted** the Committee minutes

CONCLUDING BUSINESS

TB203/20 Questions from Members of the Public

Ms Lees advised the meeting that the question received from a member of public would be treated as a formal complaint as it related to specific individual.

TB204/20 Message from the Board

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

TB205/20 Any Other Business

Mr Masom led the Board in extending gratitude to Mrs Bottomley for her contribution to the Trust during her time as Interim Director of Finance and wished her the very best for the future.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:25

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	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												

Board of Directors (Part 1)

Matters Arising Action Log

Action Log updated 28 January 2021

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
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. **January Update :** Deferred to March 2021 due to operational pressures	**Green**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	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. The last review of the BAF from March 2020 was noted to be Green (fully met the requirements) across all areas. **January Update :** There were no specific recommendations for the Trust to action as a result of this. However, there were some suggested best practice approaches incorporated into the review and it's positive to note that these have all been incorporated into the new BAF and review process. **Action Complete**	**Blue**
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. **December Update**: Mrs Armstrong-Child advised that informal sessions had been arranged with colleagues to discuss how to shape the inclusion agenda. The North West BAME Assembly had been developed and the submission is due by 22 December. This will form part of the Board Development Day in January. It was noted that Mr Singh has been involved in drawing up of the BAME Assembly template. **January Update:** This was included on the Agenda for the Board of Directors' Strategy session. **Action Complete**	**Blue**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3 FEBRUARY 2021**
Agenda Item	**TB005/21**	**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 last Board meeting held on 2 December 2020, in relation to:

- North West Regional Chairs' Meetings
- Acute Sustainability Strategy ('Shaping Care Together')
- Covid19 Update
- Nurse recruitment
- 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 Since the last meeting in December 2020, 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 continuing to rise to the ongoing challenge of what has been an extended and through January rapidly growing second wave.

1.2 On 17 December, I joined the members of the Executive Team at the Annual Time to Shine Staff Awards which were held virtually and which celebrated the significant number of achievements made by staff in the Trust during the year. These achievements have continued throughout January and everyone should be rightfully proud of the performance challenges thrown up by Covid whilst also maintaining critical non- Covid services.

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 26 January 2021 focused on:

a) Mass Covid 19 vaccination update
b) People Programme Update with discussions focused on mental health
c) Reducing burden and releasing capacity to manage Covid 19 pandemic

3. Covid19 Vaccination Update

3.1 In my last report to the Board in December, I highlighted that the Trust was preparing to take part in the roll out of the national Covid-19 vaccination programme.

3.2 On 27 January 2021, I was able to restart my weekly visits to the different parts of the hospital. First on the line was the Vaccination Hub where I spent part of my day seeing first-hand the fantastic work that our teams are doing in managing the vaccination at a trust level.

3.3 The vaccination hub is based in the Corporate Management Office and started vaccinating staff members on 4 January 2021. Since then 2,399 substantive staff of 3,245 (74%), 914 temporary staff and 1,190 other NHS, Social Care and Care Home staff have passed through the hub totalling 4,503 as of Wednesday excluding the 570 administered in the last 2 days.

4. Shaping Care Together

The formal launch of the Shaping Care together Communications and Engagement phase happened before Christmas focussing on staff members and in January this was extended to the public It represents a significant challenge to keep activity going on Shaping Care Together during these times, but the pandemic has reinforced how important it is to review and act upon the sustainability challenges facing the Trust to help us shape the health and care services we need to continue to provide after the current crisis has passed.

5. Nurse recruitment

5.1 The Trust is on route to achieving the target figure of 52 nurses as part of our recruitment campaign on the sub-continent by Easter.

5.2 I advised last time that we had welcomed six nurses from India in November who have now completed their OSCI qualification and are now part of the substantive staff complement in our wards including the ITU.

5.3 A further 18 nurses arrived in January bringing the total to 34 nurses so far. The nurses are due to complete their isolation period on 2 February before they commence our Trust Induction.

6. Charitable Funds

6.1 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.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB006/21**	**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 Time to Shine Awards 2020

This year we explored innovative ways of ensuring that our annual awards ceremony would proceed despite the challenges of Covid 19. We held our first ever virtual Time to Shine Staff Awards with the ceremony broadcast online. The format meant that our staff and their friends and family were able to take part. More than 400 devices logged in to watch the event on Thursday, 17th December.

The shortlisted nominees are listed below, with the winners in **BOLD**:

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	**Haematology Clinical Nurse Specialist Rachel Chidley** Keran Carter Sara Gara
Everyday Excellence Award	Phil Capper Mary Stead **Ward Clerk Kathy Hickson**
Improvement Award	Home First Therapy team Neonatal Unit **Medical Education Centre**
Clinical Mentor of the Year	Sarah Ralph Rachelle Alty **Staff nurse 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 **Advanced Therapy Assistant and Trainee Assistant Practitioner 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**

1.2 Thanks a Bunch Award

This month the Deputy Chief Executive presented the award to all our colleagues involved in setting up and running our staff vaccination service.

1.3 National Joint Registry Quality Data Provider

The Trust was named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits.

The NJR monitors the performance of hip, knee, ankle, elbow, and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients. The registry collects high quality orthopaedic data to provide evidence to support patient safety, standards in quality of care and overall cost effectiveness in joint replacement surgery.

In order to achieve the award, hospitals are required to meet a series of six ambitious targets during the audit period 2019/20. The team worked extremely hard to achieve this.

2. Trust News

2.1 Covid-19

It has been a really challenging start to the new year. Community infection rates of Covid-19 continued to rise significantly in early January. We anticipated that this would have a significant impact on the demand for our hospital services. At the time of writing this report, 41% of our bed occupancy consists of patients who are Covid positive and demands on our critical care beds remain high. Whilst we have had to reduce some of our planned elective programmes, we have continued to treat patients in high priority categories including patients requiring treatment within 28 days and cancer patients.

We have continued to focus on driving down nosocomial infections with daily Executive oversight, seven days a week. We continue to monitor all our infection control practices and compliance through the Infection Prevention and Control Board Assurance Framework. An update will be presented at today's Trust Board.

We have been working closely with Clinical Commissioning, Local Authority, and Community colleagues to increase capacity by focussing on discharging patients as soon as it is safe to do so. A task force that seeks to improve discharges and increase patient flow has been created with colleagues from organisations across the system represented on the team and reaching into the hospital daily.

The Trust's vaccination hub went live from 4 January and we are delighted to report that we have been able to extend our vaccination programme to colleagues from health and social care outside the Trust. At the time of writing this report the team had vaccinated over 4,000 health and social care workers.

2.2 Shaping Care Together

Despite the pressures of Covid-19, the Shaping Care Together (SCT) Programme Board continues to progress. The engagement and communication with staff and public has now been launched. There is a dedicated Shaping Care Together website that people can access and leave their views: https://yoursayshapingcaretogether.co.uk.

3. News and Developments

3.1 Annual Baby Remembrance Service

The chaplaincy team and bereavement midwives at Ormskirk Hospital usually hold a memorial service every December in the baby memorial garden for anyone who has experienced the loss of a baby.

This year due to the ongoing Covid-19 restrictions, the team instead recorded a similar service in the garden, which went online on Wednesday, 9 December and has so far been watched 230 times. The service included the spiritual care team, local singers, lead bereavement midwife Jo Unsworth and myself sharing poems, songs, and thoughts.

3.2 Big Names Joined Our Calendar of Celebration and Thanks

We marked the countdown to Christmas with a Calendar of Celebration and Thanks with video messages each day from 40 individuals, including sports personalities, comedians, and Hollywood stars, as well as NHS leaders, local politicians, patients, and fundraisers. James Bond himself, actor Daniel Craig, concluded the celebrations on Christmas Day. A very big thank you to all the staff involved in the planning of this.

4. Reportable Issues Log

Issues occurring between 21.11.20 – 25.01.21.

4.1 Serious Incidents and Never Events

No Never Events to report.

Four Serious Incidents reported to StEIS and currently under investigation. These relate to falls with harm and potential failure to diagnose.

4.2 Level Four and Five Complaints

Two level four complaints received and relate to treatment and communication. These will be investigated through the Trusts Complaints Policy.

4.3 Regulation 28 Reports

No regulation 28's issued.

5. Media coverage

- NHS Parliamentary Awards 2020 recognises Ormskirk children's diabetes team (In Your Area, 5 December) https://www.inyourarea.co.uk/news/nhs-parliamentary-awards-2020-recognises-ormskirk-childrens-diabetes-team/
- 'Fantastic work' of Ormskirk children's ward praised (QLocal Ormskirk, 16 December) https://ormskirk.qlocal.co.uk/ormskirk/news_list/%27Fantastic_work%27_of_Ormskirk_childrens_ward_praised-55048693.htm
- Hospital parking charges return (Southport Visiter, 24 December)
- It's another day in the world of midwifery – midwife talks about life at Christmas (Ormskirk Advertiser, 31 December)
- Southport Hospital and Ormskirk Hospital views sought as future planning begins (Stand Up For Southport, 13 January) https://standupforsouthport.com/southport-hospital-and-ormskirk-hospital-views-sought-as-future-planning-begins/
- Hospital's data gran signposts better care (Ormskirk Advertiser, 14 January)
- MP Damien Moore insists A&E services must remain at Southport Hospital (QLocal Southport, 18 January) https://www.qlocal.co.uk/southport/news_list/MP_Damien_Moore_insists_A_amp%3BE_services_must_remain_at_Southport_Hospital-55049065.htm
- Locals asked to give feedback on hospitals (Champion News, January) https://www.champnews.com/story.asp?id=GN4_ART_1798850
- Have your say on hospital services (Southport Visiter, 21 January)

6. Risk Register and Board Assurance Framework

The updated Board Assurance Framework (BAF) in full has been presented at January's Audit Committee and all strategic objectives have also been presented to relevant sub-committees. The BAF is on this month's Trust Board Agenda.

Trish Armstrong-Child
Chief Executive
Date 2 January 2021

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB007/21**	**FOI Exempt**	**No**
Report Title	**INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK (IPC BAF)**		
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 of Directors with an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Board Assurance Framework (BAF).

Executive Summary

The IPC BAF was first reported to the Board in July 2020. The latest version of the IPC BAF 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. Updates to the IPC BAF since the last report to Board are highlighted in red.

The table below provides an update on progress since the last update to Board in December 2020 (covering November 2020's position).

Rating	Nov 20	Jan 21	Change
Completed	55	73	+18
Progressing on schedule	39	22	-17
Slightly delayed and/or of low risk	1	0	-1
Significantly delayed and/or of high risk	0	0	0
TOTAL	**95**	**95**	

Since the last report, a number of initiatives have been developed to monitor progress including:

- Roll out of staff Covid-19 Vaccination Programme as of 20 January 2,970 first doses have been administered
- PPE Donning and Doffing training is now recorded on ESR. As of **19.01.2021**, a total of **886** staff from a number of disciplines have been recorded as compliant.
- Fit Testing - Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit, as of **19.01.2021**, we have **1991** staff training records.
- Trust has procured isolation screens between bed spaces – they are currently being installed across the Trust (both sites) – As of **15.01.2021** 10 wards and clinical areas on Southport site have been completed. Instillation continues in other areas. Ormskirk will be completed after Southport site.

In addition, IPC audits and mandatory training continues to be monitored:

- Hand Hygiene Audits - Trust compliance Dec 2020 **(99.3%)** ↑

- PPE Compliance Audits - Trust compliance Dec 2020 (**99%)** ↑
- IPC Mandatory Training - Compliance –
  - Level 1 Dec 20 (**90.93%)** ↓ above target
  - Level 2 training Dec 20 **(78.84%)** ↓ **below** target.

Mitigating Actions have been developed for potential gaps in assurance, details of which are included in the template.

In addition, NHSE/I have introduced the '10 Key actions: Infection Prevention and Control and Testing' document, a summary version of the full IPC BAF. We have developed a reporting template to monitor compliance; this is presented to Silver and Gold Command on a weekly basis.

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.

Recommendations	
The Board of Directors 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** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	✓ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
☐ **SO3** Efficiently and productively provide care within agreed financial limits	
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Andrew 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 **red**

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 (Nov 20)	New BRAG Rating (Jan 21)
Systems and processes are in place to ensure:					
• infection risk is assessed at the front door and this is documented in patient notes	Risk assessments used in • ED (Adults & Children's) also Red and Green areas • Out patients – patient temperatures monitored at front door • Maternity	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. • Risk assessments in place. Patients moved accordingly. • All bed moves considered in 3x daily bed meetings (7 days a week) • No patient is moved unnecessarily	None identified	N/A		
• compliance with the national guidance around discharge or transfer of COVID-19 positive	• Patients are swabbed prior to discharge or transfer and status is documented in discharge summary • All patients discharged are given	None identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
patients	relevant information				
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Ward Walking by Quality Matrons and IPC Team • Hand Hygiene Audits (Trust compliance End Dec 2020 **(99.3%) – Achieved target** • PPE Compliance Audits for End Dec 2020 **(99%)** - Achieved target	Potential for inadvertent non-compliance by individual staff in clinical areas	• Ward Walking by Quality Matrons, IPC Team and senior leaders • Weekly Perfect Ward audits 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 Dec 2020 **(99%)**	Potential for inadvertent non-compliance by individual staff in clinical areas Due to current pressures on wards, the role of Covid Champions has not been implemented.	• Staff redeployed to IPC Team to support Ward Walking and promoting PPE compliance • Ward Walking by Quality Matrons, IPC Team and senior leaders • 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 / Lateral Flow testing has been offered to all patient facing staff 4. 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 Dec 20 **(90.93%)** – Target achieved • Level 2 training Dec 20 **(78.84%) – below target** • IPC training is covered in Clinical Induction which has remained	Not reached 85% target for Level 2 IPC training in December	CBUs to review staff who are shielding to ensure they are up to date with mandatory training. Frequent reminders re IPC best practice circulated in Trust News.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
included in all staff Induction and mandatory training	mandatory for all new starters during Covid • Online You Tube training		Information re IPC provided to staff at safety huddles Ward Walking by Quality Matrons, IPC Team and senior leaders		
• 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 30 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	• As of **19.01.2021**, a total of **886** staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. This figure has declined from the previous week due to staff leaving the Trust and being taken off ESR. Work is ongoing to continuously update the central training records from local records, as local areas complete their training sessions. • Fit Testing - Due to the changing availability of FFP3 respirators staff are being reassessed for respirators	Training records in relation to Donning & Doffing training is currently paper based but in process of moving to electronic (ESR)	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 – to date 886 records moved to ESR Enhance fit testing overview to allow procurement to be targeted to equipment already tested for.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	currently available using a portacount machine to check the fit. o Trust has now moved to an in-house built system and part of the improvements was data quality which has caused for erroneous records to be removed. o As of **19.01.2021**, we have **1991** staff training records (this is figure has remained the same since December 2021. Silver command is reviewing the data collection process to ensure all data is being collected • 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.				

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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.	None identified	N/A		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• As above, risks in relation to Covid-19 (PPE, equipment, service moves and staffing). Reviewed by IPC group, Gold command and Clinical Reference Group (CRG).	None identified	N/A		
• 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.	Capacity in IPC Team has been temporarily reduced by two nurses.	IPC Team temporarily supported for a short time by redeployed staff and Quality Matrons for IPC audits. Two vacant posts successfully filled (permanent Matron and 6 months Band 6). Due to start in post 01/02/21		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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.	None identified	N/A		
• 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		
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 Dec 20 (**90.93%**) – Target achieved • Level 2 training Dec 20 (**78.84%**) **–** below target • 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.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	• 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				
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Additional investment in domestic cleaning teams. • Enhanced cleaning teams already in place for high risk areas. • Enhanced cleaning and Covid isolation cleans are reported in the Covid Executive summary. In December 2020, 430 Enhanced cleans and 602 Covid Isolation cleans were carried out. • Specific training has been provided for cleaning staff including enhanced donning and doffing and fit testing. • Training records for Domestics (including fit test) and annual staff competencies are held centrally.	None Identified	N/A		
• 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 • In December 2020, 430 Enhanced cleans, 602 Covid isolation cleans and 346 other isolation cleans were	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.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	carried out.				
• 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	None Identified	N/A		
• 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 and January 2021) regarding disinfectant products to make sure we allow to air dry for at least 60 secs.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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		
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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	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 quarterly, last meeting on 25 November 2020. • Audit results from Oct 20: indication (reason for prescribing) documented in 72%; appropriateness of prescription 84%; reviewed in 72h 94% • The most recent antibiotic audit (Dec 20) provided assurance (provisional results) - indication for antibiotics were documented in 73% of patients; appropriateness of prescription of 89%; and a review was done at 72 hours for 97%. Next audit due March 2021. • New planned Antimicrobial audits (to be run in Jan 21): Omitted doses over the weekend; gentamicin dosing (re-audit); renal adjustment in antimicrobials; Teicoplanin dosing.				
• 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					

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
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, Amber 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		
• 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	visibility. • New posters in place around the Trust featuring the Medical Director				
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 checks and symptom checks completed on entrance to clinics.	None Identified	N/A		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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 be exempt as per Government guidelines.	N/A		
• staff are aware of agreed template for triage questions to ask	• Yes, set of questions identified and asked at ED and Outpatients	None Identified	N/A		
• 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 be exempt as per Government guidelines.	N/A		
• 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		
• 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.	Potentially areas where patient social distancing will be less than 2 meters due to the environment Lack of side rooms to isolate	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 Readirooms being used where		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	• Trust also reviewing the use of screens where social distancing is restricted		needs are identified. Trust has procured isolation screens between bed spaces – they are currently being installed across the Trust (both sites) – As of **15.01.2021** 10 wards and clinical areas on Southport site have been completed (an increase on 3 areas from last week). Instillation continues in other areas. Ormskirk will be completed after Southport site		
• 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		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
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		
• 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 Dec 20 (**90.93%**) – Target achieved • Level 2 training Dec 20 (**78.84%**) **–** below target • covered in Clinical Induction which has remained mandatory for all new starters during Covid • Ward Walking by Quality Matrons and IPC Team	Not reached 85% target for Level 2 IPC training in December	CBUs to review staff who are shielding to ensure they are up to date with mandatory training. Frequent reminders re IPC best practice circulated in Trust News. Information re IPC provided to staff at safety huddles		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
			Ward Walking by Quality Matrons, IPC Team and senior leaders		
• 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	• As of **19.01.2021**, a total of **886** staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. This figure has declined from the previous week due to staff leaving the Trust and being taken off ESR. Work is ongoing to continuously update the central training records from local records, as local areas complete their training sessions. • Fit Testing - Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit. o Trust has now moved to an in-house built system and part of the improvements was data quality which has caused for erroneous records to be removed. • As of **19.01.2021**, we have **1991** staff training records (this is figure has remained the same since December 2021. Silver command is reviewing the data collection process to ensure all data is being collected • 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	Training records in relation to Donning & Doffing training is currently paper based but in process of moving to electronic (ESR)	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 – to date 886 records moved to ESR Enhance fit testing overview to allow procurement to be targeted to equipment already tested for.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	across wards				
• a record of staff training is maintained	• Yes mandatory training compliance is recorded on ESR and reported monthly • Fit Testing - Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit. o Trust has now moved to an in-house built system and part of the improvements was data quality which has caused for erroneous records to be removed. •	Training records in relation to Donning & Doffing training is currently paper based but in process of moving to electronic (ESR)	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 – to date 886 records moved to ESR Enhance fit testing overview to allow procurement to be targeted to equipment already tested for.		
• 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		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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 • Hand Hygiene Audits (Trust compliance End Dec 2020 **(99.3%) –** Achieved target • PPE Compliance Audits End Dec 2020 **(99%) –** Achieved target. • Use of the IPC NHSE/I audit tool published December 2020	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 facilities including instructional posters
  • good respiratory hygiene measures
  • maintaining physical distancing of 2 metres wherever
	• Hand Hygiene facilities in all clinical areas with automated soap dispensers and paper towel dispensers
	• Instructional posters adjacent to each hand-wash basin.
	• 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
		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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
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	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		between bed spaces and exploring the use of screens as a physical barrier between patients Trust has procured isolation screens between bed spaces – they are currently being installed across the Trust (both sites) – As of **15.01.2021** 10 wards and clinical areas on Southport site have been completed (an increase on 3 areas from last week). Instillation continues in other areas. Ormskirk will be completed after Southport site		
• 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 Dec 2020 **(99.3%) – Achieved target**	None Identified	N/A		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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		
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, visitors or staff	• 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 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	Occasional movement of staff between wards and clinical areas due to capacity	If reallocation required this is advised to occur at the start of shifts to decrease the risk of cross contamination		
• areas/wards are clearly signposted, using physical barriers as	• All wards are locked down and clear signage indicating Covid zone status and PPE requirements	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
appropriate to patients/individuals and staff understand the different risk area					
• 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 Gama Redirooms are available.	Limited availability of Side Rooms	Bed base reviewed by Bed Manager, Gama Redirooms 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 Isolation screens installed between bed spaces	Bed base reviewed by Clinical Coordinator/Bed Manager, Gama Redirooms are available where possible Trust has procured isolation screens between bed spaces – they are currently being installed across the Trust (both sites) – As of **15.01.2021** 10 wards and clinical areas on Southport site have been completed (an increase on 3 areas from last week). Installation continues in other areas. Ormskirk will be completed after Southport site		
• 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 (Nov 20)	New BRAG Rating (Jan 21)
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		
• 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		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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. The capital scheme to address the storage is due to start on site w/c 25.01.21 with works planned to be complete by 31st March 2021.	All waste from clinical areas at Southport is currently classed as infectious therefore no issue with mixing of clinical waste In line with new NHSE/I requirements offensive waste (tiger bags) are being re introduced across Healthcare settings where possible. Areas at Southport site have started to introduce offensive waste back (eg ENT).		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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 4,000 staff calls, in addition to responding to emails and supporting managers and staff with the risk assessment process • We are continuing to provide	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	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		
• 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 centrally**	• 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 that can be used and where they can be located. 700 half face reusable respirators have been procured • Over 400 staff have been fitted with	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. Fit Testing - Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
	the reusable respirators. • 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. The central record is now in place however does not contain corpro mask testing currently. Working on ensuring this information is included centrally. • Portacount system now in place and is gold standard for FIT testing. Testing Hoods also still in use.		o Trust has now moved to an in-house built system and part of the improvements was data quality which has caused for erroneous records to be removed. o As of **19.01.2021**, we have **1991** staff training records (this is figure has remained the same since December 2021. Silver command is reviewing the data collection process to ensure all data is being collected		
• 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. • List of testers now included on central record	None Identified	N/A		
• 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	• 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.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
different model is used	• Portacount system now in place and is gold standard for FIT testing. Testing Hoods also still in use.				
• 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. • The central record is now in place however does not contain corpro mask testing currently. Working on ensuring this information is included centrally. • List of testers now included on central record	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.		
• 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		
• 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	• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
skills and experience and in line with nationally agreed algorithm					
• 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		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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 should include a centrally held record of results which is regularly reviewed by the board	• Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available using a portacount machine to check the fit • Reported in IPC BAF which is presented at Quality & Safety Committee and Trust Board • Reported in IPC 10 Key Questions weekly to Silver and Gold Command.	None Identified	N/A		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Nov 20)	New BRAG Rating (Jan 21)
• 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		
• 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.	None Identified	N/A		
• 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		

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Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2020**
Agenda Item	**TB008/21**	**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 also highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendation

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

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 – December 2020

Indicator Name	December 2019	November 2020	December 2020	Trend
Overall Trust A&E attendances	10,825	7,694	7,557	▼
SDGH A&E Attendances	4,804	3,945	4,030	▼
ODGH A&E Attendances	2,900	1,439	1,242	▼
SDGH Full Admissions Actual	1,187	1,315	1,418	▲
Stranded Patients AVG	183	153	157	▼
Super Stranded Patients AVG	69	52	48	▼
MOFD Avg Patients Per Day	71	36	42	▼
DTOC Unconfirmed Avg Per Day	9	-	-	
GP Referrals (*Exc. 2WW*)	2,261	1,602	1,328	▼
2 Week Wait Referrals	605	745	724	▲
Elective Admissions	152	181	151	▼
Elective Patients Avg. Per Day	5	6	5	

Activity Summary – November 2020

Southport and Ormskirk Hospital NHS Trust

Indicator Name	December 2019	November 2020	December 2020	Trend
Elective Cancellations	27	18	22	↓
Day case Admissions	1,757	1,390	1,237	↓
Day Case Patients Avg. Per Day	57	46	40	↓
Day Case Cancellations	39	27	28	↓
Total Cancellations (EL & Day Case)	66	45	50	↓
Total Cancellations (On or after day of admission, non clinical reasons)	8	10	1	↓
Outpatients Seen	19,865	20,345	18,535	↓
Outpatients Avg. Per Day	641	678	598	↓
Outpatients Cancellations	3,814	3,911	3,922	↑
Theatre Cases	534	452	436	↓
General & Acute Beds Avg. Per Day	448	437	434	↓
Escalation Beds Avg. Per Day	15	3	0	↓
In Hospital Deaths	103	94	87	↓

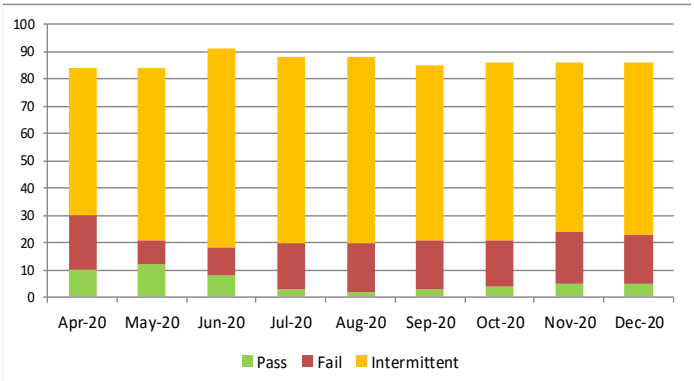
Southport and Ormskirk Hospital NHS Trust

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 5. In the Quality section the WHO Checklist, Sepsis – Timely Identification, CHPPD and the HSMR are assured. In Workforce the Mandatory Training metric is assured. It is important to remember that, in this instance, the assurance measure is a mathematical calculation so does not take into account the real-world performance of many indicators, which are now existing in a very different climate. For example, the Trust has always had excellent RTT performance, however following Covid this declined and has not yet returned to pre-Covid levels. Current performance shows these indicators to be failing, but in real terms performance is excellent and operationally it is assured.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Pass	10	12	8	3	2	3	4	5	5
Fail	20	9	10	17	18	18	17	19	18
Intermittent	54	63	73	68	68	64	65	62	63



Although the number of assured indicators has stayed the same there has been a change, with the A&E conversion rate no longer assured (due to a recent increase following a decline in minors attendances during the second lockdown period) and CHPPD now becoming assured.

One less indicator is failing this month – DSSA breaches are now classed as intermittent following a sustained period of positive variation.

Reporting by exception, the 18 indicators which are failing to provide assurance include 2 from Quality, 5 in Operations, 2 in Finance and 9 in Workforce.

In the Quality section the Induction rate and Percentage of Deaths screened are not assured. The Board should also note that the number of stillbirths and the SHMI are also showing recent negative variation so require additional scrutiny.

Within Operations A&E compliance and Ambulance handovers 30-60 minutes, ODGH bed occupancy and theatre utilisation are not assured. RTT indicators, diagnostic waits, Stroke, Cancer 14 day and the DNA rate are all showing recent negative variation which may impact assurance rating if this continues. Supplemental action plans have been provided for key metrics to provide assurance that issues have been identified and actions are in place to correct course.

In Finance the Agency Staff Cost(%) and Distance from Agency Spend Cap are failing, however both are showing recent positive variation. The Pay, Non Pay and Bank & Agency run rate are all showing negative variation.

Finally in the Workforce section Expenditure on bank/agency staff, PDR's, Staff turnover, Nursing and Medical vacancy rate and multiple sickness rate metrics are all failing to provide assurance.

All metrics, as well as their relative targets, will be reviewed with the Executive lead before the end of the financial year so that more appropriate and realistic targets can be assigned and performance measured against.

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Integrated Performance Report

Board Report

December 2020

Southport and Ormskirk Hospital NHS Trust

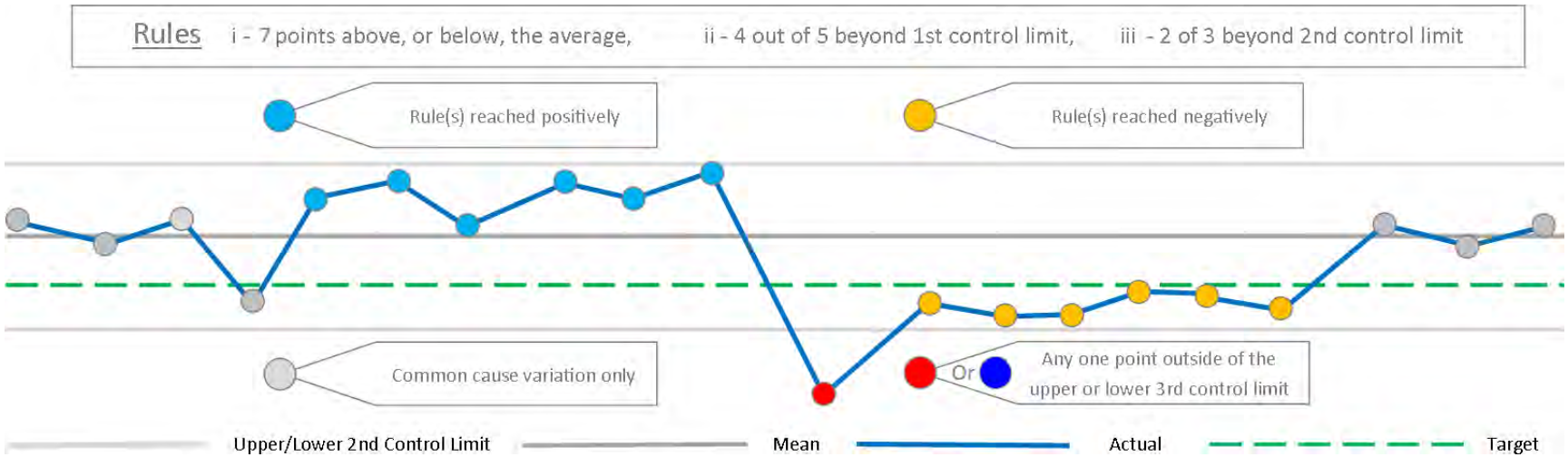
Guide to Statistical Process Control

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 Summary

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Harm Free	0	3	10	0	0	3	2	8
	Infection Prevention and Control	0	0	4	0	0	0	2	2
	Maternity	1	0	8	1	0	0	2	6
	Mortality	1	1	1	1	1	0	1	0
	Patient Experience	0	0	6	0	0	1	2	3
Operations	Access	2	0	11	4	3	1	3	2
	Cancer	0	0	3	0	1	0	0	2
	Productivity	3	0	7	2	2	0	4	2
Finance	Finance	2	0	8	3	0	4	3	0
Workforce	Agency	1	0	0	0	0	0	0	1
	Organisational Development	1	1	1	0	0	0	0	3
	Sickness, Vacancy and Turnover	7	0	4	3	0	0	0	8

Assurance

Measures the likelyhood 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:	**25 JANUARY 2021**
LEAD:	**DR DAVID BRICKNELL**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- There are elements of the detailed daily Ward drugs audit which require pharmacy support on the ward and this is now being addressed.
- Systems are now in place for appropriate levels of Ward observations and it is now a question of monitoring their application.
- There is concern that when the current pressures ease there will need to be significant support for staff related to wellbeing.

ADVISE

- Although an alert had been issued in relation to insulin prescription, the prescribing had been correct, but did not contain advice on the precise method of delivery, which should be correctly done by the nurse specialist. This service is being expanded.
- Assurance has been received in relation to induction and c-section rates being above the norm. However, in the light of post Ockenden surveillance requirements, more detailed regular assurance will be given to the Committee and Board.
- Delays to neck of femur surgery were explicable, but the assurance that appropriate care had been delivered in the meantime will be the subject of audit and report to the Committee.

ASSURE

- A presentation of the award-winning initiatives in ITU during Wave 1 showed the fundamental awareness of the nature of care for both patients and families amongst our staff. These outstanding practices continue through Waves 2 and 3.
- Structured Judgement Review (SJR) of Covid patients in Wave 1 gave significant assurance of the level of care, although there were one or two shortcomings which need to be addressed. (This should be distinguished from the RCA of nosocomial infections, where there is an urgent need for the system to produce a protocol).
- Although Fragile Services will remain an Extreme risk pending system wide solutions, mitigations are in place to reduce risk to patients which will be reported to the Committee regularly.
- Regular discussions with CQC both report progress and keep us abreast of requirements. We will develop an action plan to address their likely future requirements as well as their past comments. Their Insight report shows us in the top 20% of acute hospitals despite the inclusion of out of date adverse data.

New Risk identified at the meeting

- No new risks were identified at the meeting.

Review of the Risk Register

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY AND SAFETY COMMITTEE (QSC) (Extraordinary Meeting)**
MEETING DATE:	**14 DECEMBER 2020**
LEAD:	**DR DAVID BRICKNELL**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Region asked for Trust Boards to be assured of the Structured Judgement Review (SJR) process for nosocomial COVID infections. There needs to be a defined methodology, at regional if not national level, to both attribute cases to hospital incurred infection, and to the attribution of death to COVID, and not simply to a positive test within 28 days. It is vital that every hospital uses the same methodology (and the standard SJR method is not appropriate) if there are not to be inaccurate assessments on quality of care and false comparisons between providers.

- The Board should be ASSURED that we have the processes and quality of data available when the method is agreed and that the duty of candour is a conscious factor in making the resolution of this issue urgent.

ADVISE

- Recent pressure on A&E reflected the restricted flow of patients out of the organisation, particularly if they had been COVID positive. New initiatives are being taken with Merseycare to provide post-acute care, a direct reflection of the development of a system-based approach.

ASSURE

- Nosocomial rates are down in absolute terms to 4 in the last week, and the constant vigilance on infection related measures is meeting the guidance, particularly as bed screens are being implemented on a risk related programme. As peer data is only reported in raw terms at present it is difficult to be assured that we are matching any case/bed day ratio, but we should be assured as to our nosocomial prevention measures as required by Region via the Chairs' call last week.

New Risk identified at the meeting

- No new risks were identified at the meeting.

Review of the Risk Register

Quality

Harm Free

Analyst Narrative:

No indicators within this section are currently failing in their assurance, and three are now assured, including the WHO Checklist compliance, for which the data inputting issue has been rectified. Performance on the indicators with intermittent assurance needs to be sustained.

Operational Narrative:

Hospital Acquired Pressure Ulcers:

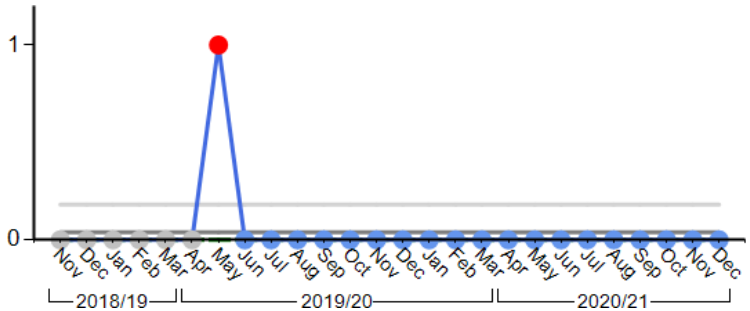
- 3 x category 3 incidents. 1 of these has been investigated, remaining 2 await investigation.
- 3 x category 2 incidents Awaiting investigation by RCA via Harm Free Care Panel.

The one case investigated showed there were some lapses in care that have been identified and appropriate action plans are now in place e.g. pressure relieving devices must be maintained and inflated.

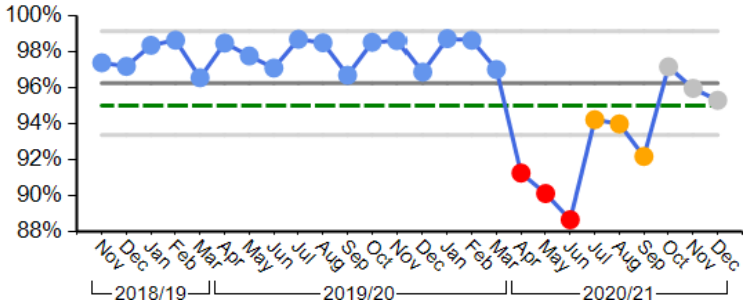
CHPPD remains above the national target. The Trust reports safe staffing at 89.6% against the national average (90%) this month. Staffing pressures remain, reflective of the pandemic, trust vacancies and sickness. Mitigating these pressures is managed daily and further supported through the trust predictive staffing tool.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Dec 20	L	0	0	Nov 20	0	0	?
VTE Prophylaxis Assessments	95%	95.3%	156	Dec 20		95%	96%	Nov 20	95%	93.4%	?
Falls - Moderate/Severe/Death	0	2	2	Dec 20	L	0	1	Nov 20	0	8	?
Patient Safety Incidents - Low, Near Miss or No Harm	822	792	792	Dec 20		822	693	Nov 20	822	6100	?
Safe Staffing	95%	89.6%	N/A	Dec 20		95%	90.7%	Nov 20	95%	89.5%	?
Fractured Neck of Femur - Operated on within 36Hours	90%	76.7%	23	Dec 20		90%	84.6%	Nov 20	90%	72.4%	?
Hospital Pressure Ulcers - Grade 2	1	3	N/A	Dec 20		2	9	Nov 20	18	50	?
Hospital Pressure Ulcers - Grades 3 & 4	1	3	3	Dec 20		1	3	Nov 20	1	12	?
WHO Checklist	99.9%	100%	0	Dec 20	H	99.9%	100%	Nov 20	99.9%	100%	P
Sepsis - Timely Identification	75%	100%	N/A	Oct 20	H	75%	100%	Sep 20	75%	100%	P
Sepsis - Timely Treatment	75%	81%	N/A	Oct 20		75%	79.3%	Sep 20	75%	76.7%	?
Care Hours Per Patient Day (CHPPD)	7.9	9.4	N/A	Dec 20	H	7.9	9.5	Nov 20	7.9	10.2	P

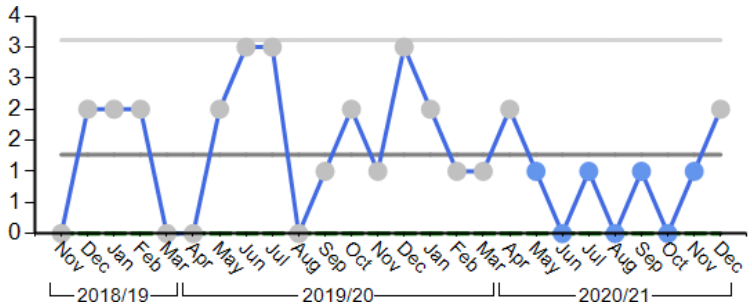
Never Events



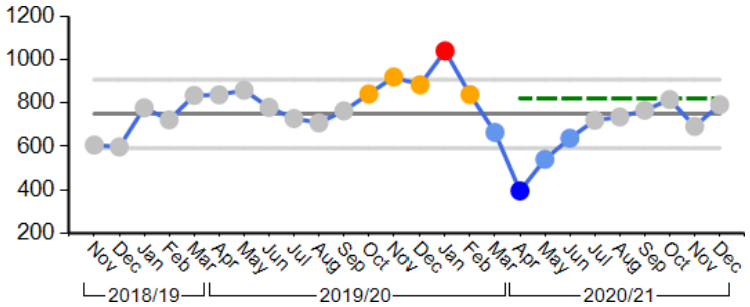
VTE Prophylaxis Assessments



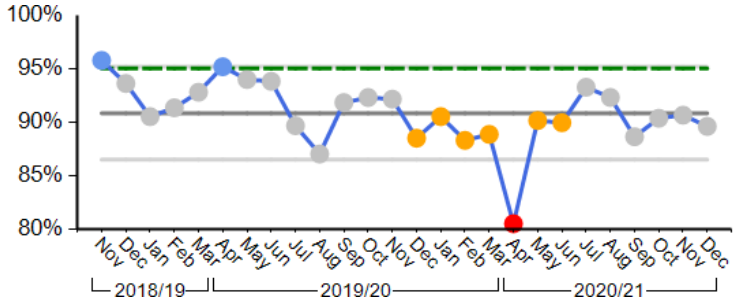
Falls - Moderate/Severe/Death



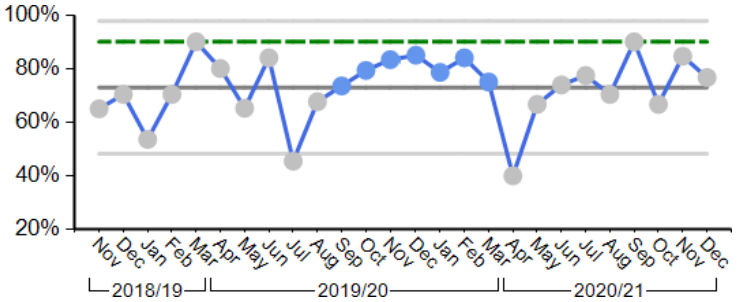
Patient Safety Incidents - Low, Near Miss or No Harm



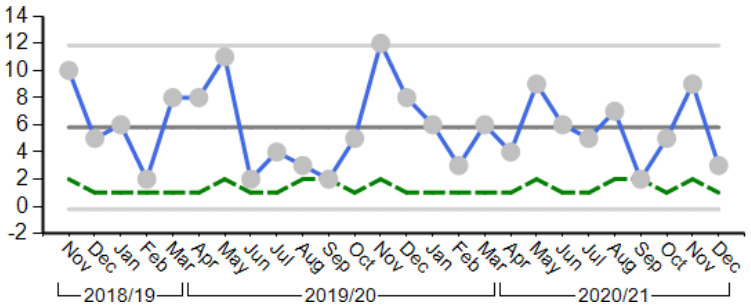
Safe Staffing



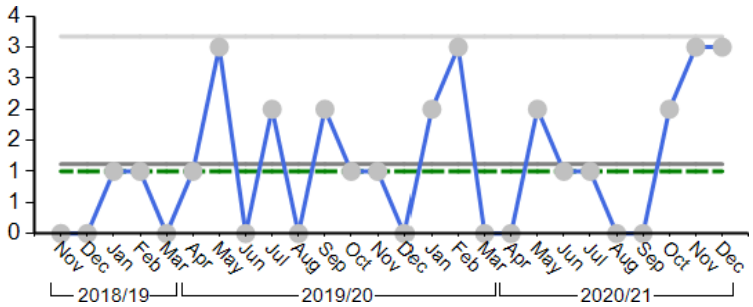
Fractured Neck of Femur - Operated on within 36Hours



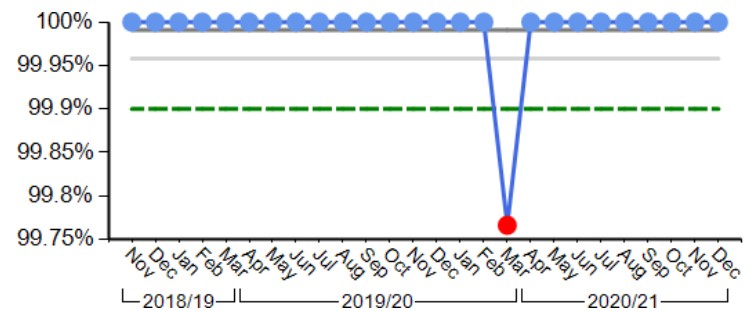
Hospital Pressure Ulcers - Grade 2



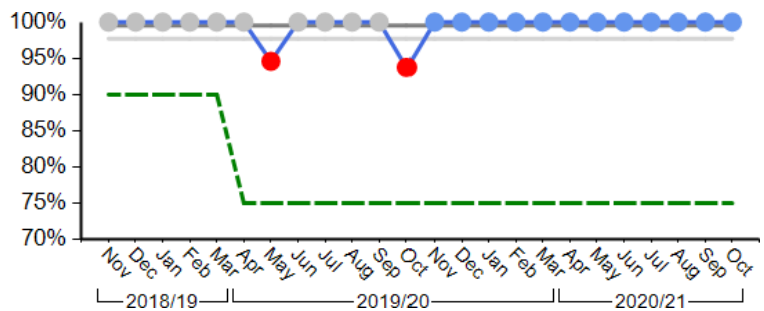
Hospital Pressure Ulcers - Grades 3 & 4



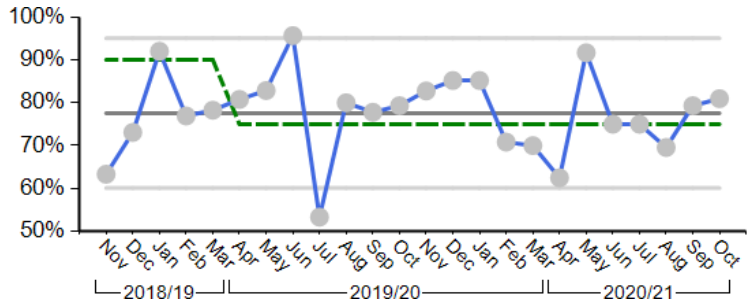
WHO Checklist



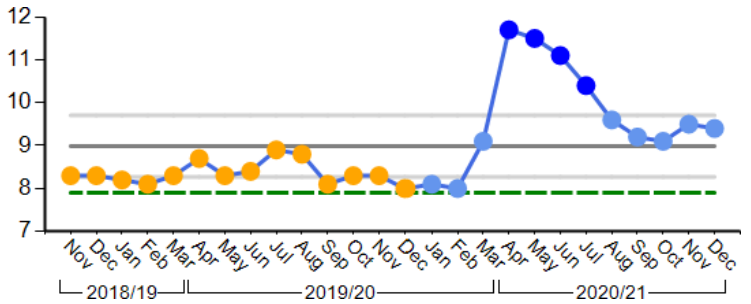
Sepsis - Timely Identification



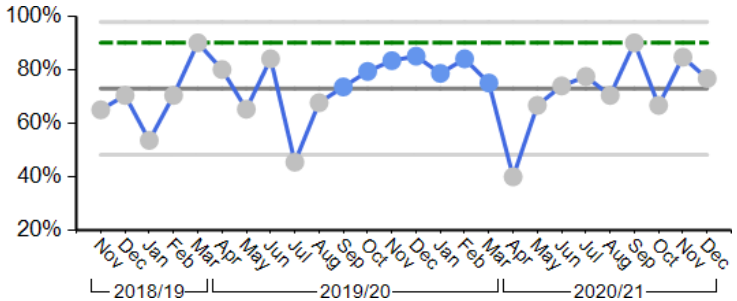
Sepsis - Timely Treatment



Care Hours Per Patient Day (CHPPD)



Fractured Neck of Femur - Operated on within 36Hours



Quality

Infection Prevention and Control

Analyst Narrative:

All indicators are intermittent in their assurance. MRSA is showing positive variation, with no reported cases since April 2020. E-Coli, whilst showing positive variation, has had the highest number reported in November and December since August 2019. Additionally, cases of C.Diff have increased for the last 2 months.

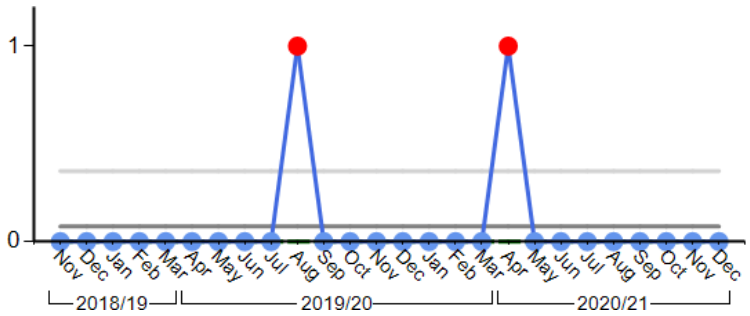
Operational Narrative:

C.Diff
C.Diff rates have increased which is in line with other trusts (PHE NW report Dec 2020). Trust rates remain average. Cases reviewed, no apparent lapses in care. Two patients had a history of C diff and required antimicrobial treatment. Other cases on G, FESS and 14A treated appropriately.

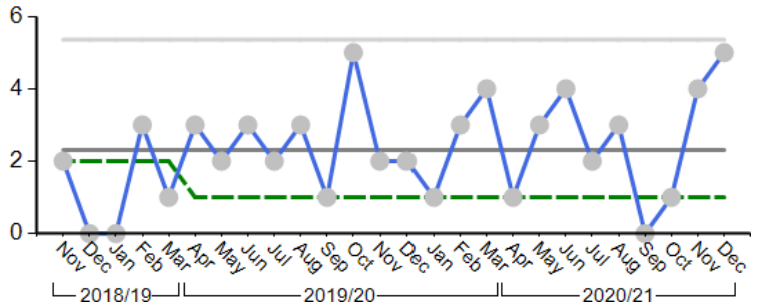
E coli
4 hospital cases and 11 community cases, no lapses of care identified. 3 of the hospital cases were due to UTI and one was due to gastrointestinal/intra-abdominal. Of the 3 UTI cases 1 of these cases was admitted due to retention and became bacteraemic 3 days later and a second patient developed retention later during their admission, the 3rd patient had decreased mobility following traumatic injury that required surgery and during their post-operative rehab developed a UTI.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Dec 20		0	0	Nov 20	0	1	
C-Diff	1	5	5	Dec 20		1	4	Nov 20	15	23	
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	6.7	N/A	Dec 20		6.9	8.1	Nov 20			
E. Coli	2	4	4	Dec 20		2	4	Nov 20	2	19	

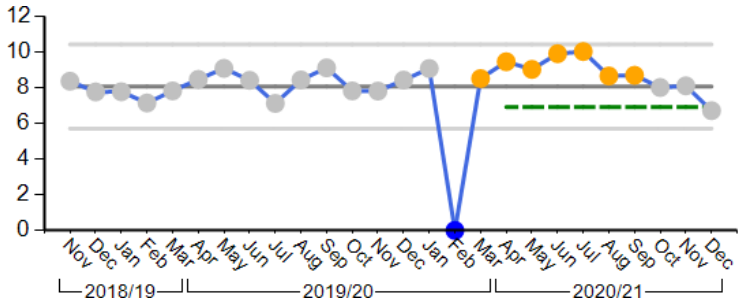
MRSA



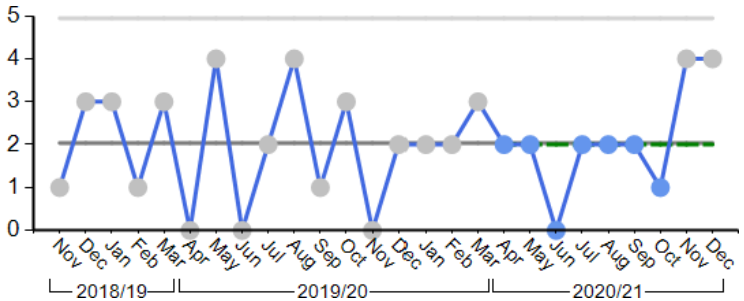
C-Diff



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



E. Coli



Quality

Maternity

Analyst Narrative:

The induction rate is the only indicator failing to provide assurance. This indicator has consistently not achieved plan and the Trust is in the upper quartile for induction rates compared to regional peers. The number of stillbirths is showing negative variation but there have been no reported stillbirths since October 2020. Whilst not statistically significant, both the caesarean section and induction rates have increased in December.

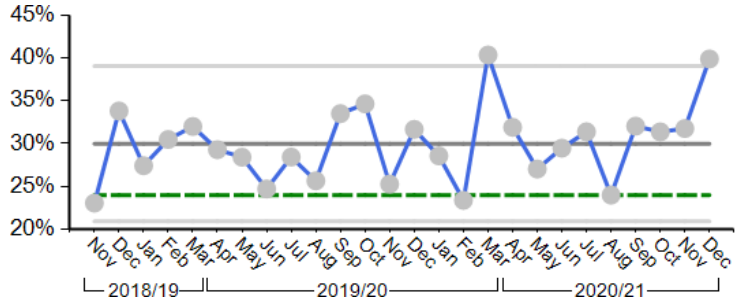
Operational Narrative:

The regional dashboard data for induction rates shows variance from 27- 42%. A recent audit completed showed compliance with guideline. Further audits are planned to triangulate inductions with outcomes. This will be monitored through the PIDA process. Through the local Maternity system, a check and challenge process will commence regarding regional dashboard performance and sharing of best practice. There is a correlation between an increased induction rate and increased c-section rate as some cases of induction will fail/become high risk and go on to be a c-section. There has been an increase of 1.9% in women induced for reduced fetal movements which accounts for some of the increase in the induction rate indicator in month. Caesarean sections are subject to regular audits with any themes disseminated as required.

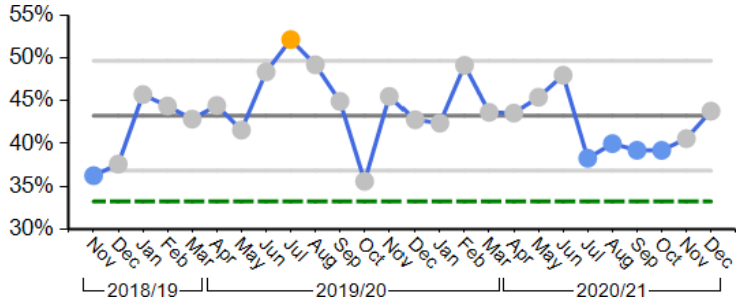
The report relating to stillbirths and near misses will be shared at SIRG at the end of January.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Caesarean Rates	24%	39.9%	61	Dec 20		24%	31.8%	Nov 20	24%	30.8%	?
Induction Rate	33.3%	43.8%	67	Dec 20	L	33.3%	40.6%	Nov 20	33.3%	41.9%	F
Breastfeeding Initiation	60%	56.4%	65	Dec 20		60%	60.2%	Nov 20	60%	60%	?
Percentage of Women Booked by 12 weeks 6 days	90%	93.2%	15	Dec 20		90%	94.6%	Nov 20	90%	94%	?
Number of Occasions 1:1 Care Not Provided	0	0	0	Dec 20	L	0	0	Nov 20	0	0	?
Number of 3rd/4th Degree Tears	0	4	4	Dec 20		0	2	Nov 20	0	23	?
Number of Maternal Deaths	0	0	0	Dec 20		0	0	Nov 20	0	0	?
Number of Stillbirths		0	0	Dec 20	H		0	Nov 20		5	?
Number of Maternity Complaints	0	2	2	Dec 20		0	2	Nov 20	0	7	?

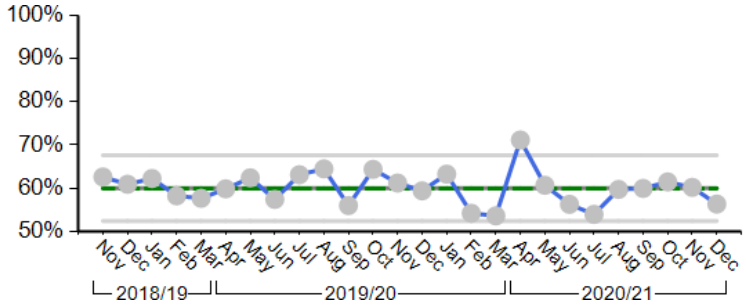
Caesarean Rates



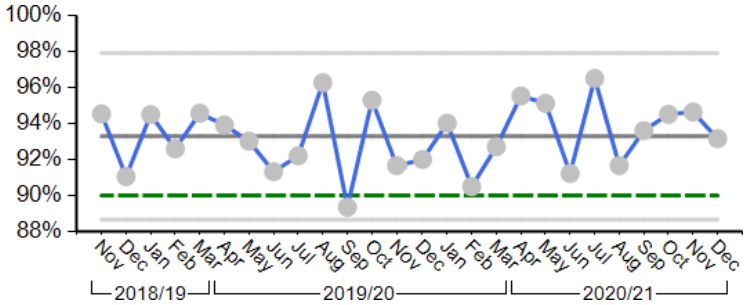
Induction Rate



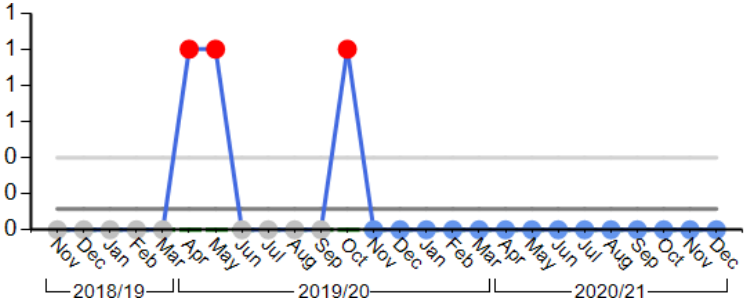
Breastfeeding Initiation



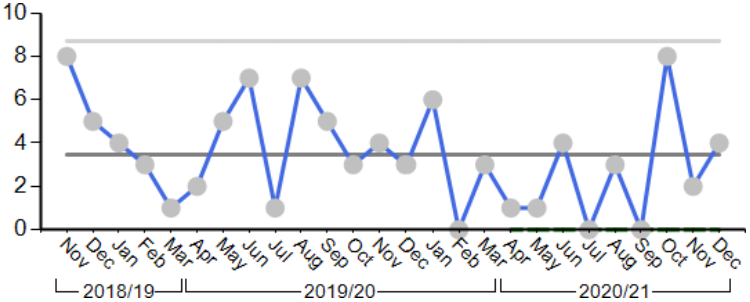
Percentage of Women Booked by 12 weeks 6 days



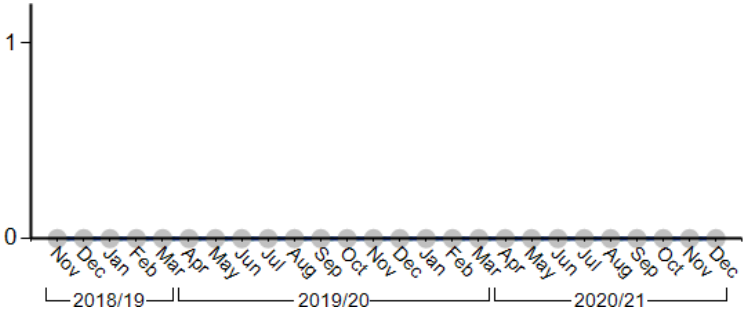
Number of Occasions 1:1 Care Not Provided



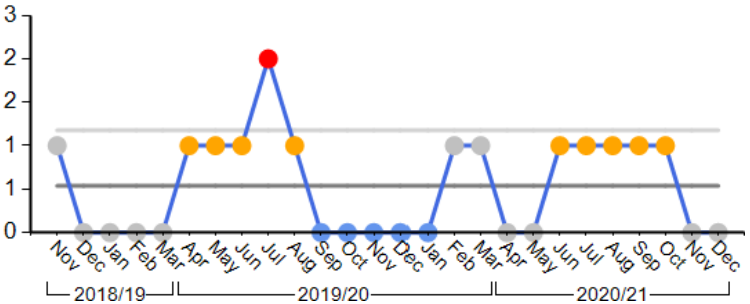
Number of 3rd/4th Degree Tears



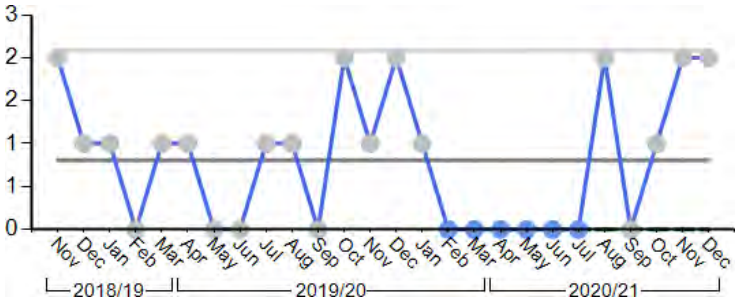
Number of Maternal Deaths



Number of Stillbirths



Number of Maternity Complaints



Quality

Mortality

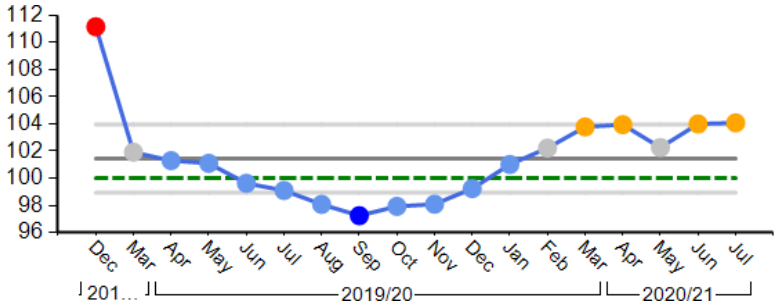
The Trust SHMI was demonstrating sustained improved performance up until January 2020 data was included. Since then it has declined but remained within the 'as expected' bracket. The decline in SHMI is largely a result of the out of hospital rate, which is more a reflection of the decrease in the number of expected out of hospital deaths rather than an increase in the number of observed out of hospital deaths.

The HSMR has demonstrated a sustained downward trajectory and the Trust is now one of the best in the country for this metric. Unlike the SHMI this is a result of both an increase in the number of expected deaths and a decrease in the number of observed deaths.

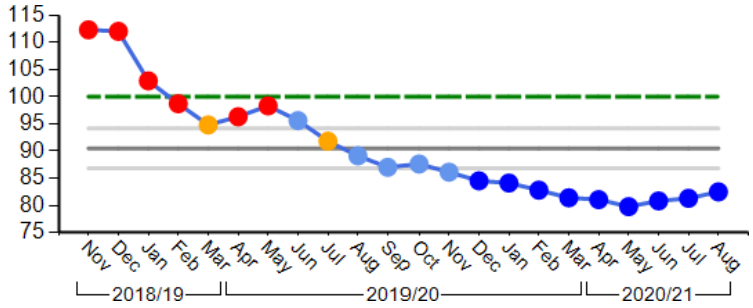
As the SHMI and HSMR are externally calculated metrics the Trust also monitors its internal mortality rate through a crude rate and excess death rate. Both of these are showing assurance with the only statistical variation coming from the two Covid waves in 2020. The Trust is currently recruiting for a Medical Examiner's Officer whose role will include the screening of all in-hospital deaths.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	104.1	N/A	Jul 20	H	100	104	Jun 20	100	103.6	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	82.5	N/A	Aug 20	L	100	81.3	Jul 20	100	82.5	P
Percentage of Deaths Screened	100%	14.1%	79	Nov 20	L	100%	12.6%	Oct 20	100%	25.8%	F

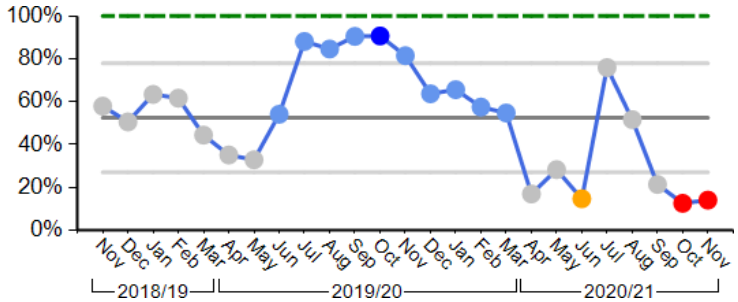
SHMI (Summary Hospital-level Mortality Indicator)



HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Quality

Patient Experience

Analyst Narrative:

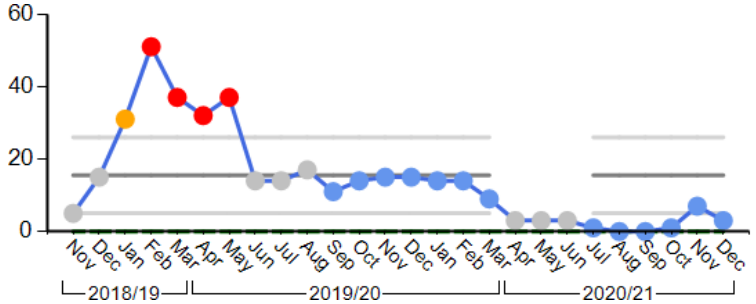
No indicators are currently failing in their assurance measures but equally none are assured. Sustained improvement needs to be realised for the indicators within this section to be assured. Following an increase in November, the complaints average turnaround time has returned to performing only marginally above the target.

Operational Narrative:

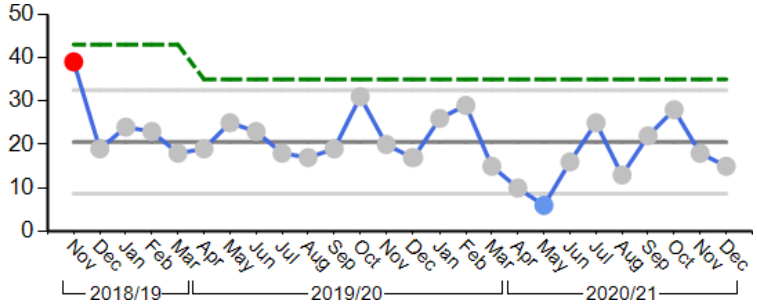
Complaints average turnaround has significantly improved following issues caused by staff absence. A weekly complaints clinic has been established and has contributed to the improvements in this area.

	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	3	3	Dec 20	L	0	7	Nov 20	0	12	?
Written Complaints	35	15	15	Dec 20		35	18	Nov 20	537	153	?
Complaints Average Turnaround Time	40	42.5	N/A	Dec 20	L	40	67.2	Nov 20	40	41.8	?
Duty of Candour - Evidence of Discussion	100%	100%	0	Dec 20	H	100%	100%	Nov 20	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Dec 20		100%	100%	Nov 20	100%	96.8%	?
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%	?

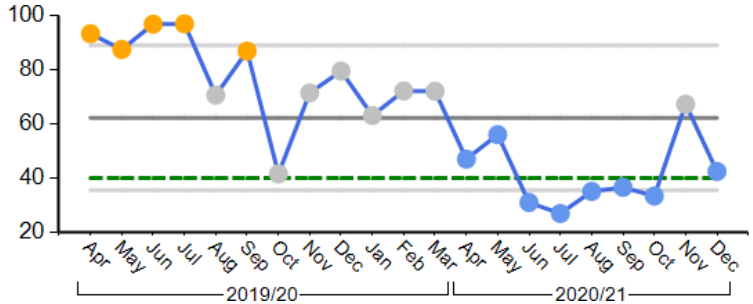
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



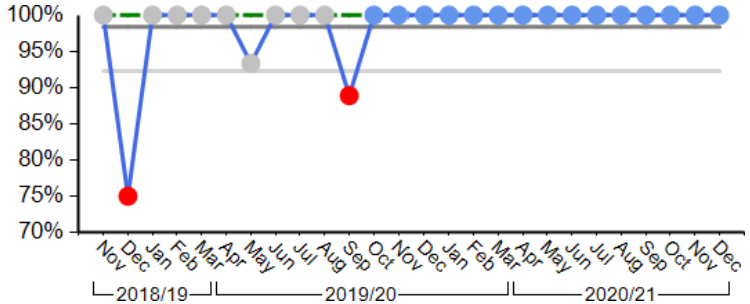
Written Complaints



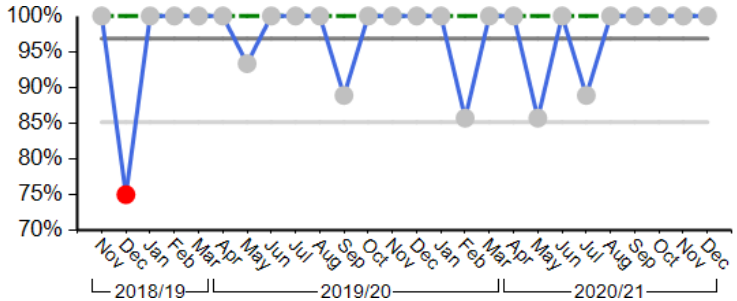
Complaints Average Turnaround Time



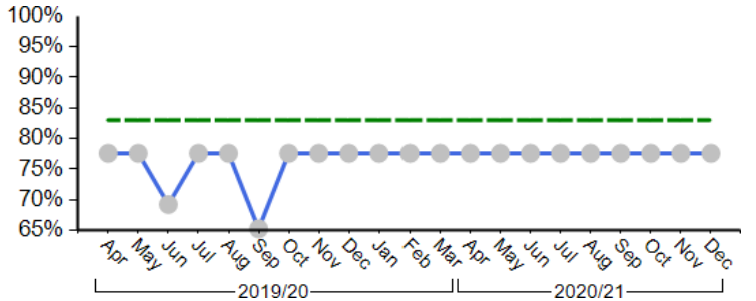
Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



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



NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB010/21**	**FOI Exempt**	**No**
Report Title	**CQC PROGRESS REPORT**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To provide an update on progress against the CQC Improvement Plan.

Executive Summary

Significant progress has been made in relation to the improvement plan. The last Quality Assurance Panel (QAP) met on 22nd December 2020 and reviewed evidence. CBUs and Corporate Leads have the opportunity to present any actions and evidence they are proposing to move to Green or Blue, in addition there's an opportunity to discuss any actions that are not delivering to plan.

There are currently 43 recommendations signed off as Blue / Complete. The report also identifies some recommendations that are at risk of non completion by the end of January 2021

For information a summary of progress in relation to the Use of Resources Action Plan can also be founds at section 4 of this report, the Finance, Performance and Investment (FP&I) committee oversee the progress of this action plan and some small updates were made at the recent committee meeting, which will be reflected in the next update report.

Recommendations

The Board of Directors is asked to note the current position against the CQC Improvement Plan and the current status of the Use of Resources Action plan.

Previously Considered By:

Quality & Safety Committee

Strategic Objectives

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

Prepared By:	**Presented By:**
Jo Simpson	Bridget Lees

NHS
Southport and Ormskirk Hospital
NHS Trust

Care Quality Commission (CQC) Update – December 2020

1. PURPOSE OF REPORT

The Care Quality Commission (CQC) carried out an inspection at the Trust between 10th July 2019 and 1st August 2019 and a well-led inspection between 20th and 22nd August 2019. The subsequent inspection report was published on 29 November 2019 where the Trust received a rating of Requires Improvement (RI).

An improvement plan was developed following the outcome of the inspection and the purpose of this report is to provide an update on progress with completion of the actions.

The report also includes an overview of progress with the Use of Resources Action Plan, a summary table can be found in Section 4.

2. PROGRESS TO DATE

Significant progress has been made in relation to the improvement plan. The last Quality Assurance Panel (QAP) met on 22nd December 2020. CBUs and Corporate Leads have the opportunity to present any actions and evidence they are proposing to move to Green or Blue, in addition there's an opportunity to discuss any actions that are not delivering to plan.

As stated in the Board Assurance Framework (BAF) the aim is to complete the CQC Must and Should Do actions by the end of January 2021, subject to Covid-19 pressures. Progress against actions in January 2021 will be reviewed by QAP in February 2021 and will be reported to Quality & Safety Committee in March 2021, this will also include a summary of any actions that cannot be closed and mitigation in place to address any outstanding issues.

To ensure consistency of monitoring in line with other key performance indicators, an overview of the numbers of outstanding actions will be presented at Performance, Improvement, Delivery and Assurance (PIDA) for each clinical business unit (CBU). The focus of this will about driving timely completion of the actions as part of the single accountability framework.

The table below provides an update on progress as agreed at Quality Assurance Panel in December 2020.

	October 2020			November 2020 (Agreed at December QAP)			Change
Rating	**Must Do**	**Should Do**	**Total**	**Must Do**	**Should Do**	**Total**	
Completed	3	28	31	4	39	43	+12
Progressing on schedule	16	35	51	19	39	58	+7
Slightly delayed and/or of low risk	12	29	41	8	14	22	-19
Significantly delayed and/or of high risk	0	0	0	0	0	0	0
TOTAL	**31**	**92**	**123**	**31**	**92**	**123**	

We have identified some recommendations that we may not be able to close completely by the end of January 2021, this might be due to Covid-19 pressures or circumstances outside our control. These include:

Recommendation	Risk to completion
The trust should ensure all staff have regular appraisals and complete mandatory training, specifically basic life support training and immediate life support training. (five measures).	• Covid-19 pressures may delay staff being able to complete mandatory training. • Capacity for trainers to run resuscitation training, as they have been redeployed clinically • Capacity for staff to attend resuscitation training
The trust should consider implementing improvement work to reduce the number of patient discharges and bed moves at night from the Critical Care Unit.	• Current patient flow within Trust • Current Covid-19 pressures
The trust should continue to work to reduce delayed discharges from the Critical Care Unit and prevent mixed sex accommodation for patients.	
The trust must ensure care and treatment of patients is provided with their consent. They must ensure when patients lack capacity to consent staff complete a capacity assessment in line with legislation, especially when using do not attempt resuscitation orders. (three measures)	• Trust wide quality improvement project in place and some actions are beyond the stated timescales.
The trust should ensure all staff receive simulation training appropriate to their role and grade.	• Potential delay due to current Covid-19 pressures
The trust should consider improving child and adolescent mental health services provision to a seven-day service.	• This is ultimately a decision for West Lancashire CCG as we aren't currently commissioned for this. However discussions are underway between CBU and commissioners.

Recommendation	Risk to completion
The trust must become compliant with the Falsification of Medicines Directive (FMD).	Significant progress has been made, however this is paused due to UK leaving Europe (this is outside of our control as a Trust)

3. USE OF RESOURCES UPDATE

Current Position

The Use of Resources Action Plan was reviewed by FP&I committee in October 2020, the table below demonstrates progress made since the last report. There are six areas for improvement and 17 individual actions. The table shows an overview of the status of the actions.

Rating	October 2020	December 2020	Change
Completed	2	4	+2
Progressing on schedule	9	6	-3
Slightly delayed and/or of low risk	5	5	=
Significantly delayed and/or of high risk	1	2	+1
TOTAL	**17**	**17**	

**Please note that BRAG ratings have not been validated at QAP, only reported to FP&I*

Progress continues to be made on all actions, however there are two areas where the BRAG is red / high risk to delivery –

- **'The Trust did not meet its agency ceiling as set by NHS Improvement for 2018/19 and is forecasting to miss its ceiling in 2019/20. At month 4, the Trust's agency spend is £2M above agency cap. It is spending more than the national average on agency as a proportion of total pay spend'.**

  Although we are making progress in some areas the level of agency spend remains too high. This is partly exacerbated by the agency spend incurred as a result of the COVID pandemic. The action relates to a sustained improvement in recruitment in a timely manner. Although there has been recent success in nurse recruitment vacancy rates remain high.

- **At the time of the assessment, the Trust was not meeting the constitutional operational performance standards around Cancer, Accident & Emergency (A&E) or diagnostic waiting times – The Trust should develop plans for fragile services that consider partnership arrangements to achieve clinical sustainability**

The Chief Operating Officer (COO) to draft a letter to Liverpool University Foundation Trust (LUFT) regarding this issue

4. RECOMMENDATIONS

The Board of Directors is asked to note the current position against the CQC Improvement Plan

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**FINANCE, PERFORMANCE & INVESTMENT COMMITTEE**
MEETING DATE:	**25 JANUARY 2021**
LEAD:	**GRAHAM POLLARD**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Non-urgent elective surgery has been suspended in order to help provide additional workforce capacity to cope with a surge in COVID cases. It is forecast that 60% of the Trust's total bed base will be taken up with COVID patients by the end of January 2021.
- It was reported to the committee that the current funding model will roll over to Q1 of next financial year, after which it is as anticipated that we will revert to a different funding model for the remainder of the year. This is likely to resemble more closely the pre-COVID financial model and therefore highlight the Trust's substantial underlying deficit.

ADVISE

- Although the Trust's current cash position appears healthy and is close to forecast at £18,382,000, as there will be no commissioning funding in March, cash flow is likely to present a challenge for the Trust heading in to the new financial year.
- The month 9 financial report received by the committee illustrates an underspend of £361K YTD. The Trust has signalled to the regulator our potential to achieve a £1.3m deficit outturn, outperforming the £1.7m deficit, which is currently planned. However it was noted that material uncertainties still exist, including Covid expenditure in January and the annual leave carry forward position which is currently being reviewed. The month 9 position also illustrated progress towards the achievement of 2020-21 CIP targets.
- The committee received a Use of Resources action plan RAG report. Whilst the paper was able to demonstrate progress, the Committee has requested greater assurance regarding timelines, deliverables and the RAG scorings. The paper also highlighted the adoption of a new Financial Management Framework, which will be submitted to FP&I committee in February.
- The committee received a capital programme update, which demonstrated that the Trust is on-track with capital expenditure as reported at month 9. A scoring template has been introduced to aid the prioritisation of schemes, but the committee did not feel assured that the prioritisation process relates individual schemes directly to the strategic objectives of the Trust.
- The Trust's RTT performance reported in December, is the best in the Cheshire and Merseyside region. S&O were the only Trust to outperform its 52 week waiter target and we have the lowest number of 52 week waiters as a percentage of total waiting lists, which stands at 0.6%. This, again, is the lowest in the region.
- Investment in the Emergency Care Village is contributing towards improved performance in corridor care and ambulance handover times. In comparison to January 2020 ambulance handover times have reduced from 48mins to 28mins, which is the best the region. Instances of corridor care have reduced from 453 in January 2020 to zero at the same point in 2021. That said, the Committee would like to understand further how the new ways of working have affected the conversion rate of attendances to admission, and if this is likely to have the anticipated positive impact.
- The committee received a paper illustrating the Trust's position on referrals and market

share. The committee agreed that this information, together with model hospital data and PLICs, will be used to inform a more coordinated approach to service reviews. This will include input from finance, operational teams and clinicians and will be prioritised over coming weeks. A delivery timetable for this work will be submitted to FP&I in February. It was also agreed that this data intelligence should be used strategically to help inform the direction of the Trust and Shaping Care Together.

ASSURE

- The Trust have appointed Dr Craig Rimmer to the role of CCIO, which ensures clinical leadership and engagement with IM&T.
- The committee received and approved the business planning process for 2021-22, which will have a light-touch approach in comparison to previous years, to reflect the uncertainty and changing nature of the current operating environment.

New Risks identified at the meeting:

No new risks were identified at the meeting.

Review of the Risk Register: *No action taken*

Operations

Access

Analyst narrative:

Two indicators are failing to provide assurance: A&E 4-hour compliance and Ambulance Handover 30-60 Mins.

Diagnostic waits is still showing negative variation, and despite significant improvements between July and November, this has stalled as the Trust faces the pressures of winter and the second wave of Covid-19. An action plan is in place to support the diagnostic recovery.

Several RTT indicators continue to show negative variation, as was expected due to Covid-19. Whilst the number of 30-week waiters has reduced, there has been an increase in the 42-week waiters.

The 90% stay on Stroke Ward continues to show negative variation with the continued effect of the closure of the stroke ward and the bed pressures.

Operational Narrative:

A&E 4-Hour compliance – 4-hour performance continues to be challenging, although the Trust is operating in line with the other Cheshire & Mersey trusts in terms of 4- hour performance, with COVID and high levels of non-COVID activity continuing to impact. There was an increase of incidence of 12-Hour trolley waits unfortunately, however the department maintained its zero corridor care performance and there were no reported incidents of harm as a result.

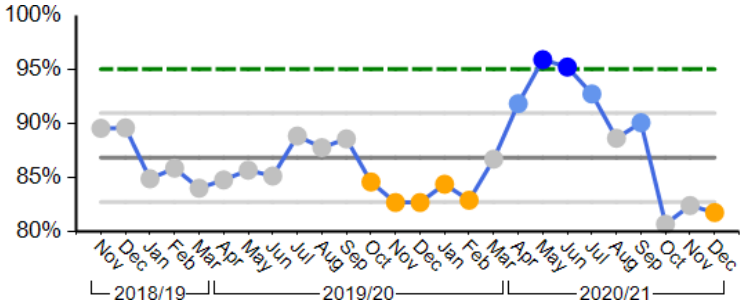
Diagnostic waits – Diagnostic performance suffered greatly in the immediate Covid-19 period, the recovery has stalled since October with the return of Covid-19 and pressures on the service. The longest waiters are for Gastroscopy, Colonoscopy and ECG. A detailed action plan is in place and is monitored monthly through PIDA.

RTT – a detailed paper was produced in November indicating the position and challenges at specialty level. The priorities remain as; improve utilisation of OP, improve utilisation of Trust Theatres, continue to utilise Renacres Theatre capacity and increase utilisation in Endoscopy now we have return of Treatment Centre estate to deliver increased activity. Recovery plans are in place across all specialities as part of Phase II. These recovery plans are monitored through PIDA.

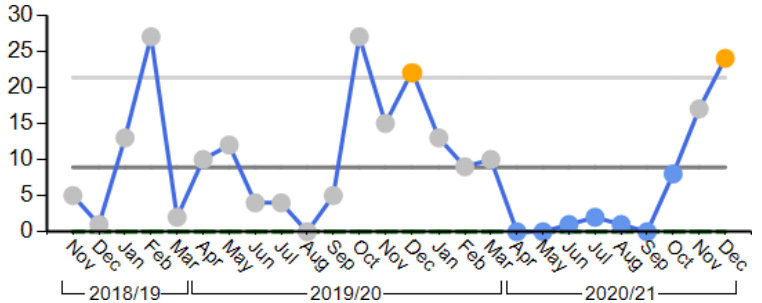
Stroke – Performance against this metric continues to present challenges. Covid-19 positive strokes cannot always be accommodated on the stroke unit and are admitted to ward 15A/15B, additionally ward 7b continues to be impacted by bed closures due to Covid-19 reducing available capacity and creating outliers. Further analysis of delays continues by the directorate manager and the stroke team to identify any future quick wins. Also see supplementary action plan for TIA/Stroke.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Accident & Emergency - 4 Hour compliance	95%	81.8%	1376	Dec 20	L	95%	82.4%	Nov 20	95%	88.5%	F
Accident & Emergency - 12+ Hour trolley waits	0	24	24	Dec 20		0	17	Nov 20	0	53	?
Ambulance Handover 30-60 Mins	0	26	26	Dec 20	L	0	45	Nov 20	0	260	F
Ambulance Handover Over 60 Mins	0	5	5	Dec 20	L	0	7	Nov 20	0	46	?
Referral to treatment: on-going	92%	84.4%	1220	Dec 20	L	92%	83.9%	Nov 20	92%	74.5%	?
52 Week Waits	0	42	42	Dec 20	H	0	39	Nov 20	0	42	?
Diagnostic waits	1%	13.4%	405	Dec 20	H	1%	12%	Nov 20	1%	28.4%	?
Stroke - 90% Stay on Stroke Ward	80%	56.3%	14	Dec 20	L	80%	44.1%	Nov 20	80%	66.8%	?
TIA	60%	60%	2	Sep 20		60%	100%	Aug 20	60%	57.9%	?
Cancelled Operations	0.6%	0.7%	9	Dec 20		0.6%	0.6%	Nov 20	0.6%	0.3%	?
Total RTT Waiting List - Trust		7801	7801	Dec 20	L		7816	Nov 20		7801	?
Total RTT waiters > 30 Weeks - Trust		463	463	Dec 20	H		676	Nov 20		463	?
Total RTT waiters > 42 Weeks - Trust		275	275	Dec 20	H		245	Nov 20		275	?

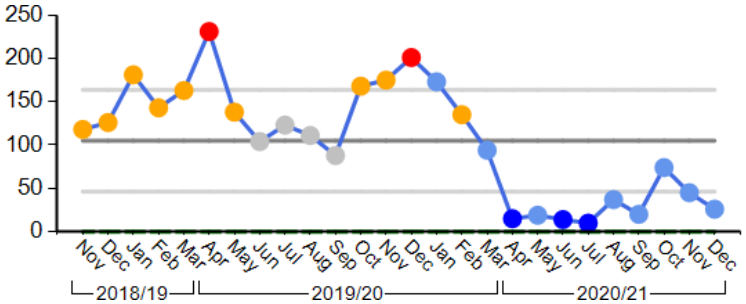
Accident & Emergency - 4 Hour compliance



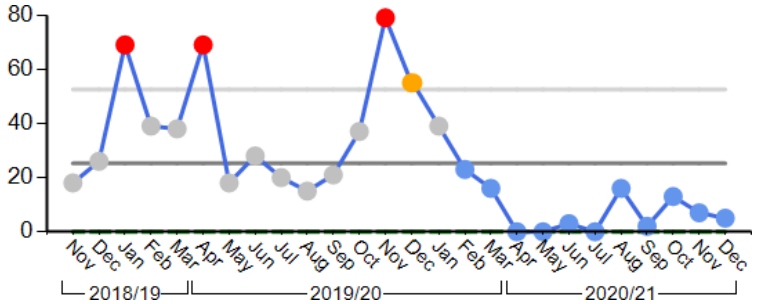
Accident & Emergency - 12+ Hour trolley waits



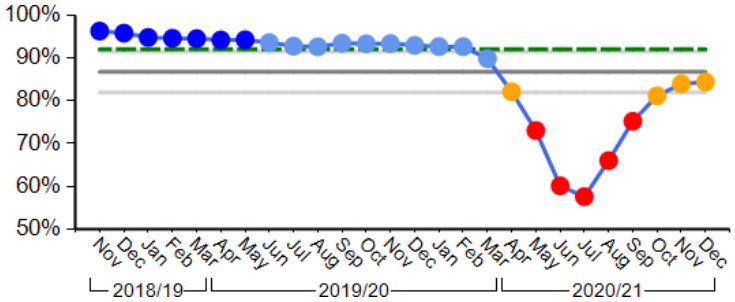
Ambulance Handover 30-60 Mins



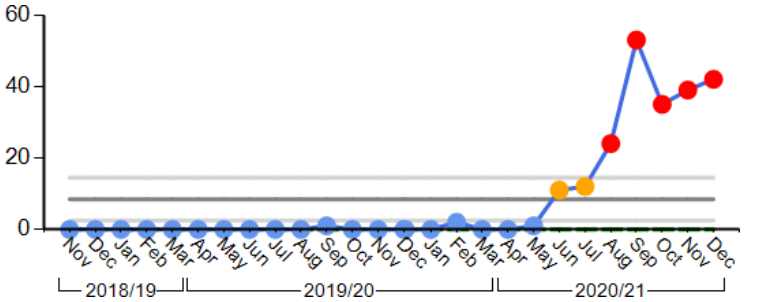
Ambulance Handover Over 60 Mins



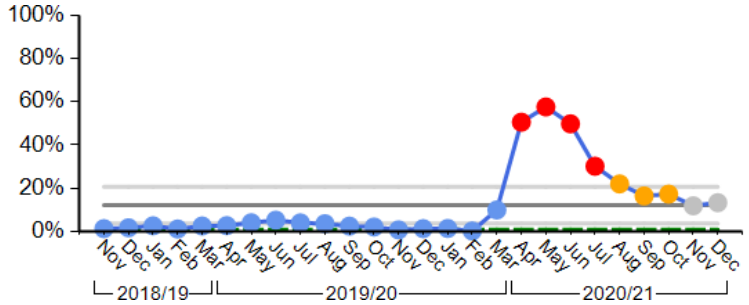
Referral to treatment: on-going



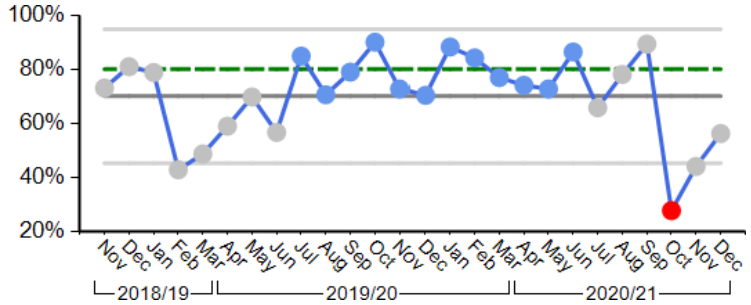
52 Week Waits



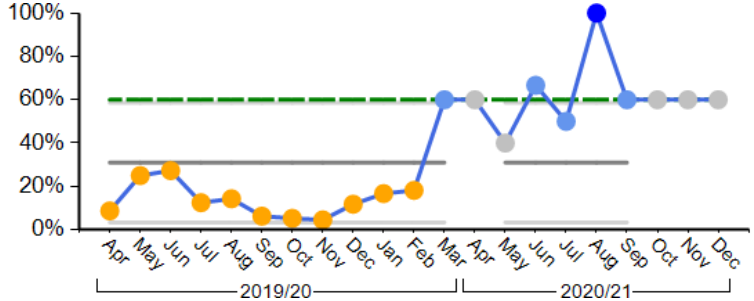
Diagnostic waits



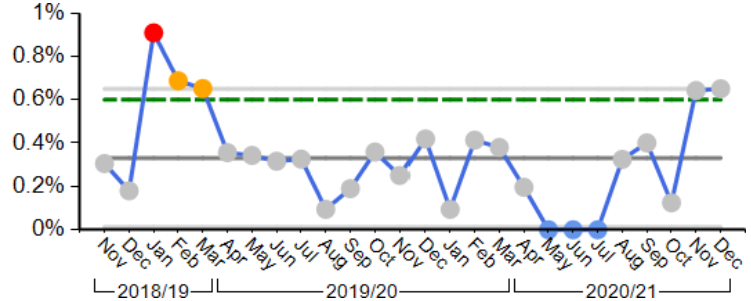
Stroke - 90% Stay on Stroke Ward



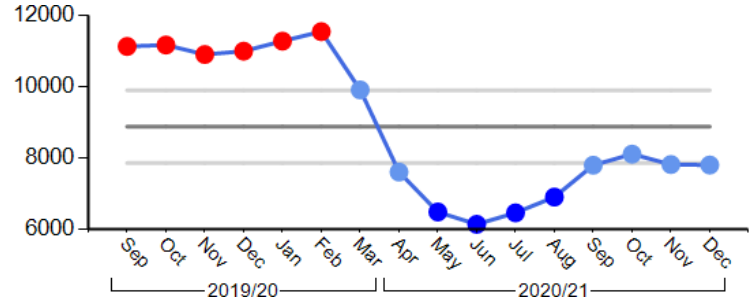
TIA



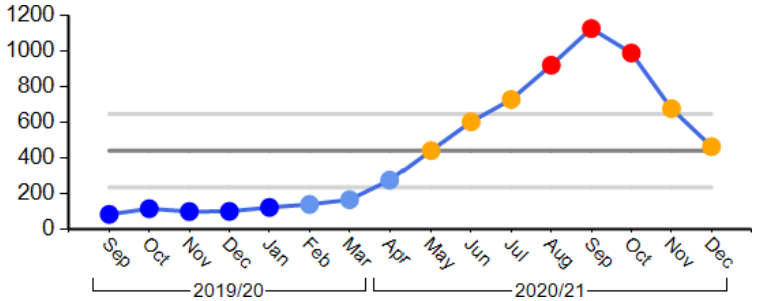
Cancelled Operations

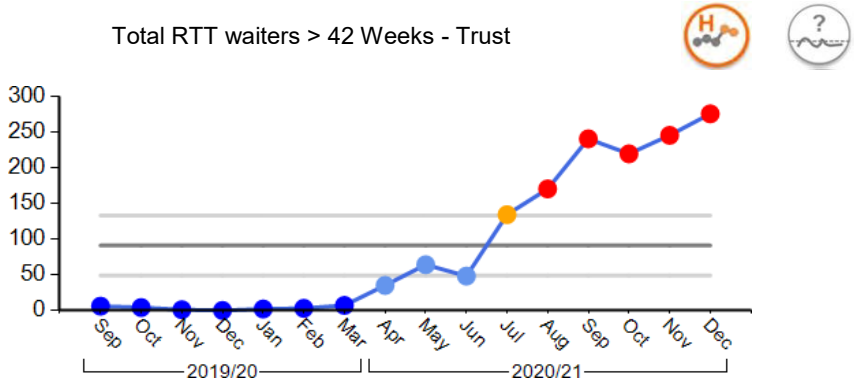


Total RTT Waiting List - Trust



Total RTT waiters > 30 Weeks - Trust

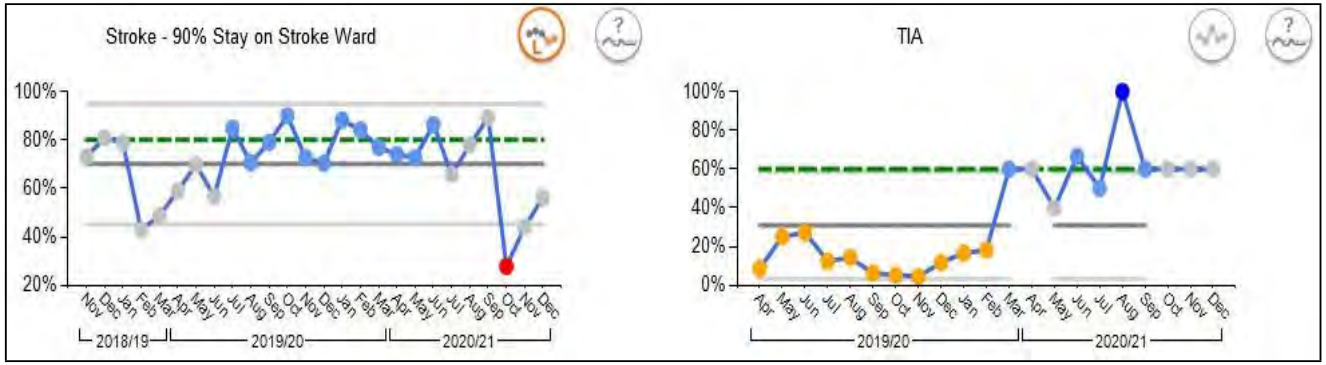



Total RTT waiters > 42 Weeks - Trust
300
250
200
150
100
50
0
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2019/20
2020/21

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%	56.3%	14	Dec 20		80%	44.1%	Nov 20	80%	66.8%	
TIA	60%	60%	2	Sep 20		60%	100%	Aug 20	60%	57.9%	



Background: Proportion of patients diagnosed with a TIA Treated within 24 hours. Threshold 60%.

Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%.

Situation: for TIA ·There were no relevant patients in December, data is from September.

For Stroke the second wave of Covid-19 has impacted this indicator, which is now showing negative variation. There have been incremental increases in November and December.

Issues:

1). Impact of Covid-19: Loss of dedicated Stroke ward due to Covid-19 during October ward re opened 04.11.20. Some of the December discharges were admitted in October.

2). Impact of Covid-19: Any Covid-19 positive patients would be admitted to any Covid-19 ward and then transferred to 7b once recovered for rehabilitation.

3). Bed capacity issues: not always the capacity to transfer patients to protected stroke bed due to impact of limited numbers of non covid-19 beds.

Actions:

- Review of validation process following pilot of SOP.
- Addition of an alert to Medway to highlight Stroke admissions to improve oversight currently with PAS Team for feasibility.
- MIAA Audit undertaken, report due next month.
- Review of Surge Plan to review speciality ward needs against Covid-19 demand

Mitigations:

- Impact of Covid-19: Stroke ward re-opened to admissions on 04 November.
- Continue to monitor Covid-19 positive patients through bed meting and transfer any patients from Stroke ward at earliest opportunity
- Surge plan reviewed through Clinical Reference Group (CRG) as required

Operations

Cancer

Analyst narrative:

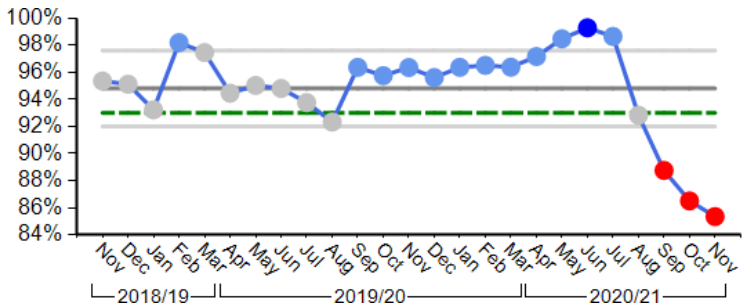
The 14-day GP referral to Outpatients is showing recent negative variation with a further decrease in November. This is a cause for concern which requires action to address. The 31-day treatment achieved the plan in November, this performance needs to be sustained to be assured. Performance on the 62-day GP referral indicator is variable, with deterioration in November. This requires further narrative.

Operational narrative:

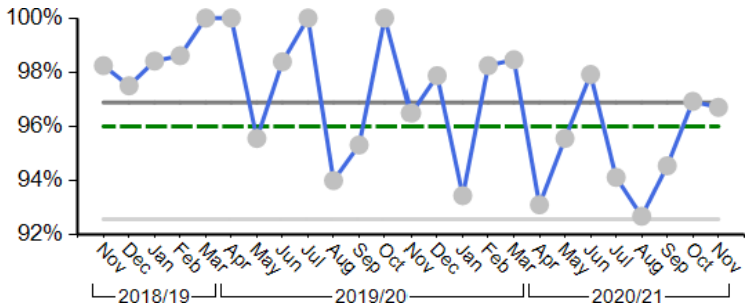
See supplementary action plan.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	85.3%	129	Nov 20		93%	86.5%	Oct 20	93%	92.4%	
31 day treatment	96%	96.7%	3	Nov 20		96%	96.9%	Oct 20	96%	95.4%	
62 day GP referral to treatment	85%	74.6%	18	Nov 20		85%	84.8%	Oct 20	85%	78.9%	

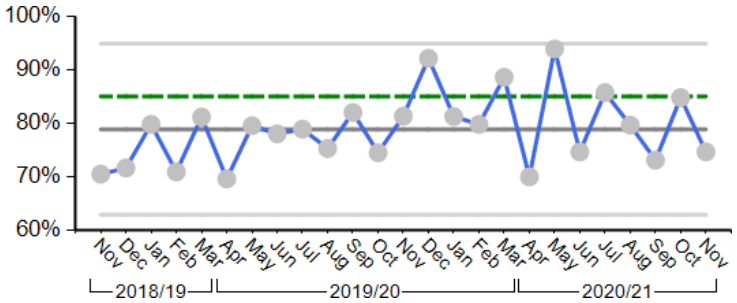
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment

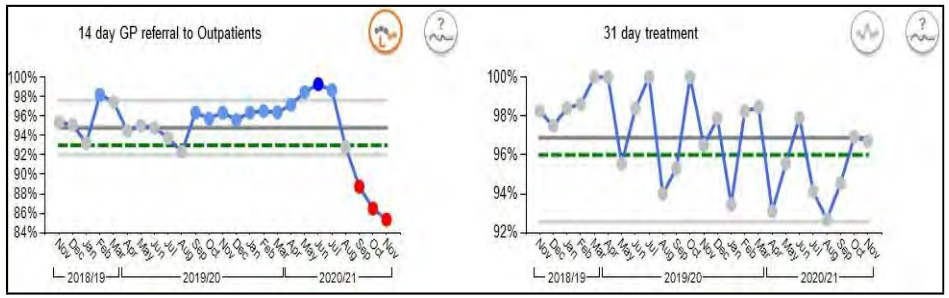


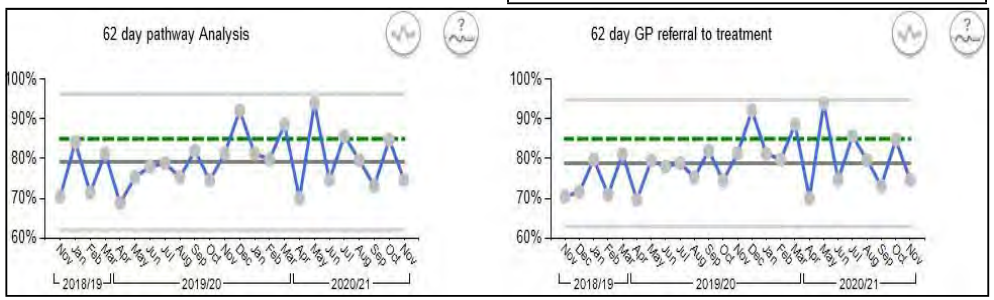
Cancer Measures

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%	85.3%	129	Nov 20		93%	86.5%	Oct 20	93%	92.4%	
31 day treatment	96%	96.7%	3	Nov 20		96%	96.9%	Oct 20	96%	95.4%	
62 day pathway Analysis	85%	74.6%	18	Nov 20		85%	84.8%	Oct 20	85%	78.9%	
62 day GP referral to treatment	85%	74.6%	18	Nov 20		85%	84.8%	Oct 20	85%	78.9%	

Situation: 14 Day cancer performance has shown further deterioration in November.
31-day treatment is showing no significant variation and has achieved plan in November.
Both 62-day measures are intermittent in their performance.





Issues

- The Trust was not compliant for the 62- and 14-day national standards. Covid-19 continues to have a significant impact on our ability to provide timely services.
- 14-day target – failure of this target continues to be primarily due to issues in the endoscopy department around capacity and staffing. The department has not succeeded against its improvement plan and this is resulting in breaches for both upper and lower GI patients.
- 31-day target – despite 3 breaches, the large total number of patients who were treated has resulted in compliance against this target in November.
- 62 day - there were 18 accountable breaches against this standard in November.
  - prostate biopsy probe was broken causing diagnostic delays in urology
  - patients self isolating and swabbing delays, endoscopy & theatre capacity.
  - tertiary centres having their own COVID related problems which impact on our patients when they are referred over

Actions:

- Activity in endoscopy is still below demand, causing delays in patient's pathways. In addition to restrictions resulting from the need for single-sex lists, there are now staff illness to accommodate. The building of new changing facilities, required for mixed sex lists to resume, has been pushed back until Feb which will continue to negatively impact on compliance against the 14-day target.
- Covid-19 restrictions are still impacting on capacity in theatres, with colorectal and urology losing most of their weekly lists. Some theatre staff have been redeployed to assist with ventilated patients. Use of the cancer hub at Whiston is still being actively encouraged, and 5 colorectal patients have been sent for surgery, with additional patients of ours going from tertiary centres too.
- Patients at day 48 on the PTL to be discussed in detail at Cancer Performance to reduce the numbers of patients in the 62-103-day category of the PTL

Mitigations:

- 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.
- Urology is risk stratifying the urgency of its patients for surgery to better accommodate theatre session requirements.
- Weekly monitoring of patients coming up to breach date (1-14 days left) to reduce size of 62-103 PTL.
- New early diagnosis support worker appointed in upper GI and Gynae, both due to start in post beginning of February.
- New trackers appointed to ensure timely and robust management of PTL
- Pre-op teams undertaking swabs for Target patients to avoid previous delays

Operations

Productivity

Analyst narrative:

Three of the indicators within the Productivity section are currently failing to provide assurance; Theatre Utilisation SDGH, Theatre Utilisation ODGH and Bed Occupancy ODGH. The increase in the Southport A&E Conversion rate is also indicative of the poorly patients attending and requiring admission in December. This has had a direct impact on the increased bed occupancy in SDGH.

Four indicators are showing recent negative variation; DNA rate, Theatre Utilisation ODGH, Bed Occupancy ODGH and A&E Conversion rate. The DNA rate has increased significantly in December and has breached the plan; further narrative and corrective action is required to understand the specialties affected and the reasons for DNA. Detailed action plans relating to Theatre Utilisation and Bed Occupancy ODGH have been updated this month and are included.

Operational Narrative:

There has been a further increase in the SDGH Conversion rate, reflecting the increased acuity presenting in ED in December.

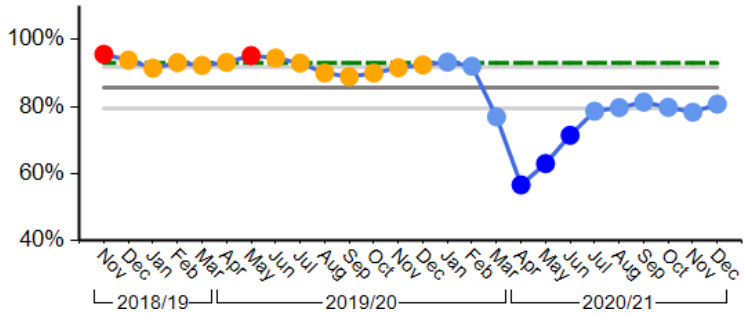
Whilst the number of super-stranded patients has decreased marginally, the number of stranded patients has increased; this is largely due to delays in discharging patients post COVID; the trust demographic and restrictions accessing community bed bases.

The DNA (Did Not Attend) rate has increased further in month. Covid-19 issues continue to cause problems with patients being asked to self-isolate etc. The text reminder service is being re-launched from January 2021. Plans are also underway to review the possibility of patient initiated follow-ups for some specialties.

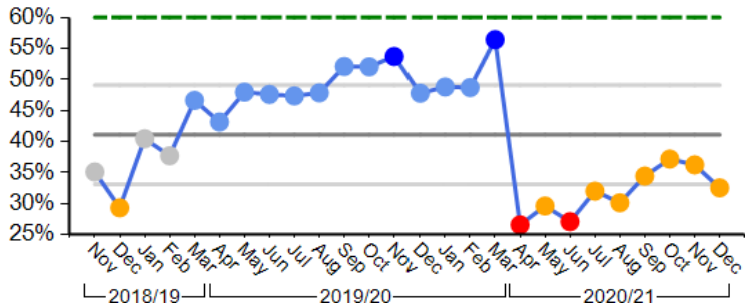
See also supplementary action plans for Theatre Utilisation and Bed Occupancy ODGH.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	93%	80.7%	N/A	Dec 20	L	93%	78.3%	Nov 20	93%	74.5%	?
Bed Occupancy - ODGH	60%	32.5%	N/A	Dec 20	L	60%	36.2%	Nov 20	60%	31.7%	F
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	42	42	Dec 20	L	50	36	Nov 20	50	36	?
Stranded Patients (>6 Days LOS)	170	157	157	Dec 20	L	170	153	Nov 20	170	1238	?
Super Stranded Patients (>20 Days LOS)	58	48	48	Dec 20	L	58	52	Nov 20	58	393	?
New:Follow Up	2.63	2.5	N/A	Dec 20	H	2.6	2.4	Nov 20	2.63	2.5	?
DNA (Did Not Attend) rate	8%	8.1%	1629	Dec 20		8%	7.9%	Nov 20	8%	6.5%	?
Theatre Utilisation - SDGH	85%	60.6%	N/A	Dec 20	L	85%	52.8%	Nov 20	85%	54.4%	F
Theatre Utilisation - ODGH	95%	65.9%	N/A	Dec 20	H	95%	59.7%	Nov 20	95%	51.9%	F
Southport A&E Conversion Rate	28%	31.9%	1283	Dec 20		28%	30.7%	Nov 20	28%	27.8%	?

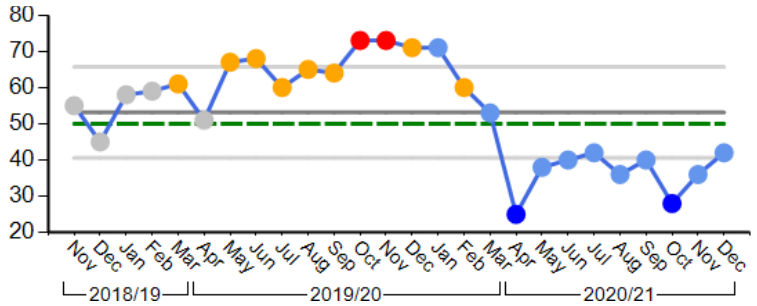
Bed Occupancy - SDGH



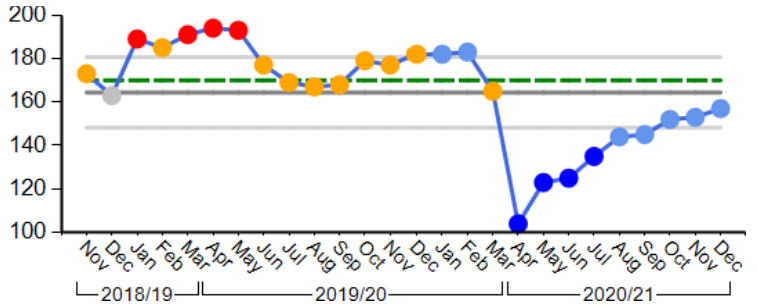
Bed Occupancy - ODGH



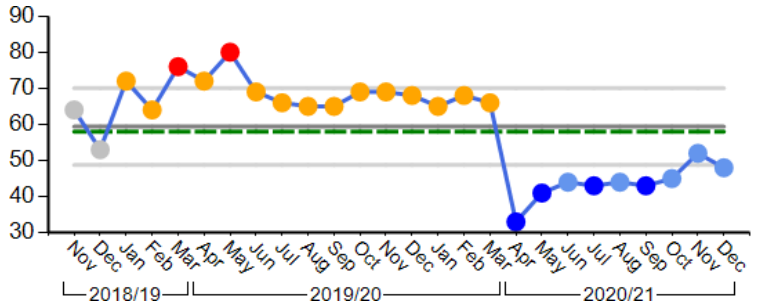
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month



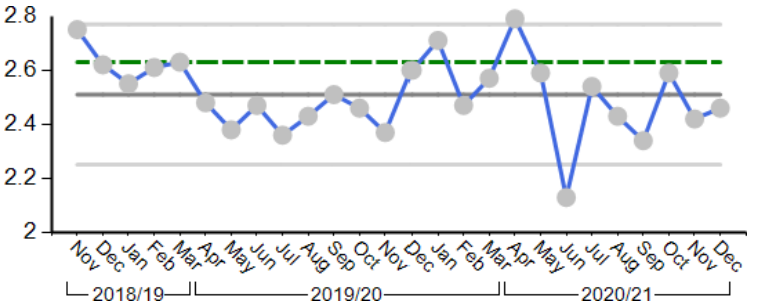
Stranded Patients (>6 Days LOS)



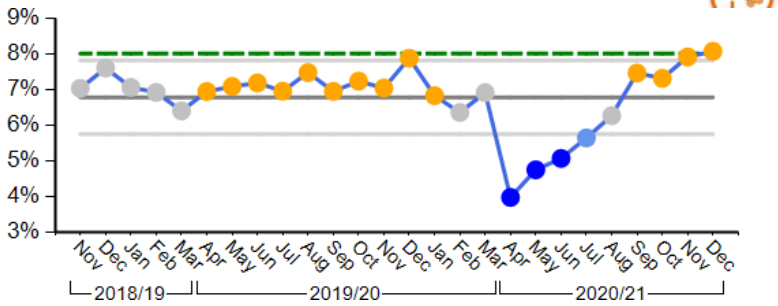
Super Stranded Patients (>20 Days LOS)



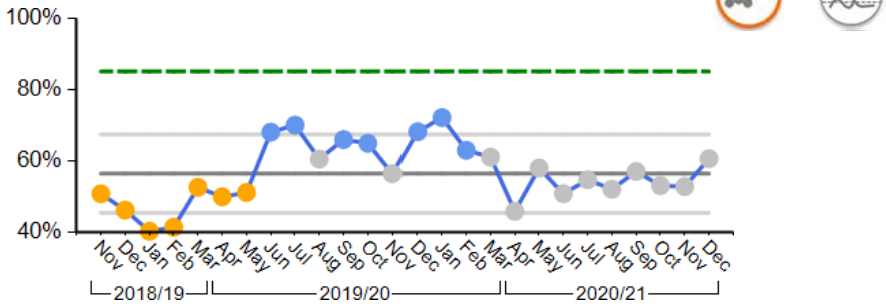
New:Follow Up



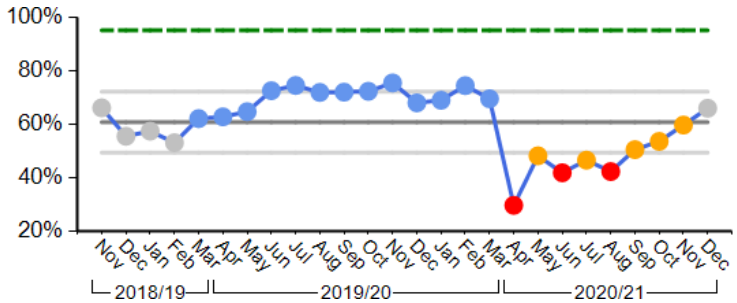
DNA (Did Not Attend) rate



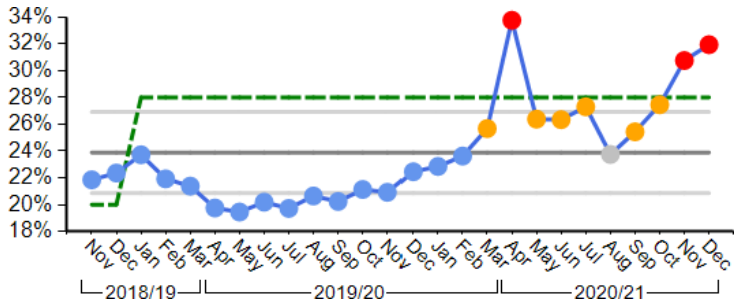
Theatre Utilisation SDGH



Theatre Utilisation - ODGH



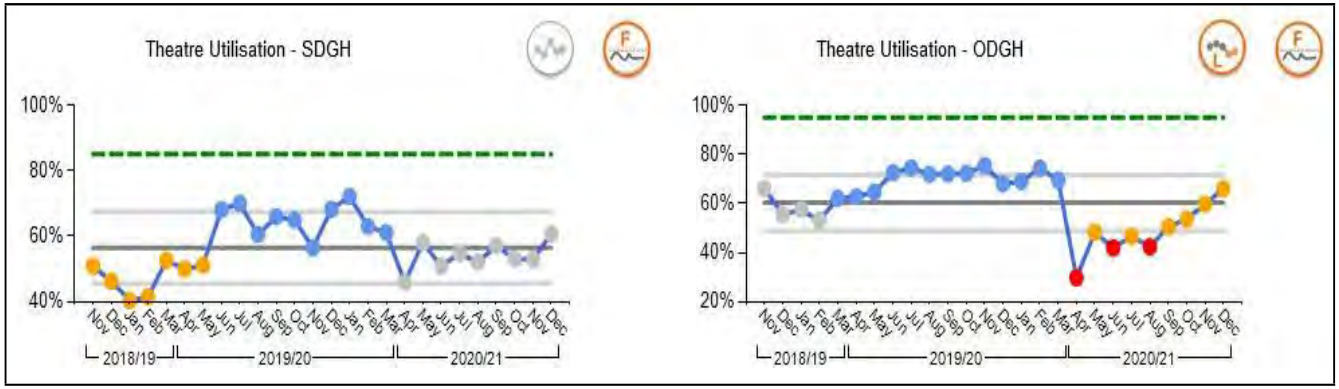
Southport A&E Conversion Rate



Theatre Utilisation

Southport & Ormskirk Hospital NHS
NHS Trust

Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Theatre Utilisation - SDGH	85%	60.6%	N/A	Dec 20		85%	52.8%	Nov 20	85%	54.4%	
Theatre Utilisation - ODGH	95%	65.9%	N/A	Dec 20		95%	59.7%	Nov 20	95%	51.9%	



Background: The proportion of 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

Improvement in utilisation in both SDGH and ODGH in December and both are performing above the mean.

Issues:

- Improvements in theatre utilisation at ODGH continued in December and achieved the 65% target set at PIDA to allow for the impact of the on-going Covid-19 restrictions.
- Improvements are also noted on the Southport site, but performance is impacted by bed capacity.
- There remains challenges in terms of backfilling elective lists following cancellations due to isolation and Covid-19 swabbing guidance.
- The Theatre Utilisation plans are considered to be unrealistic targets which cannot be achieved without a considerable Estates piece of work.

Actions:

- Introduce KPI's to review on-time starts.
- Ongoing engagement of clinical teams.
- Analysis of the theatre utilisation of peer Cheshire and Mersey Trusts to review the plan going forward

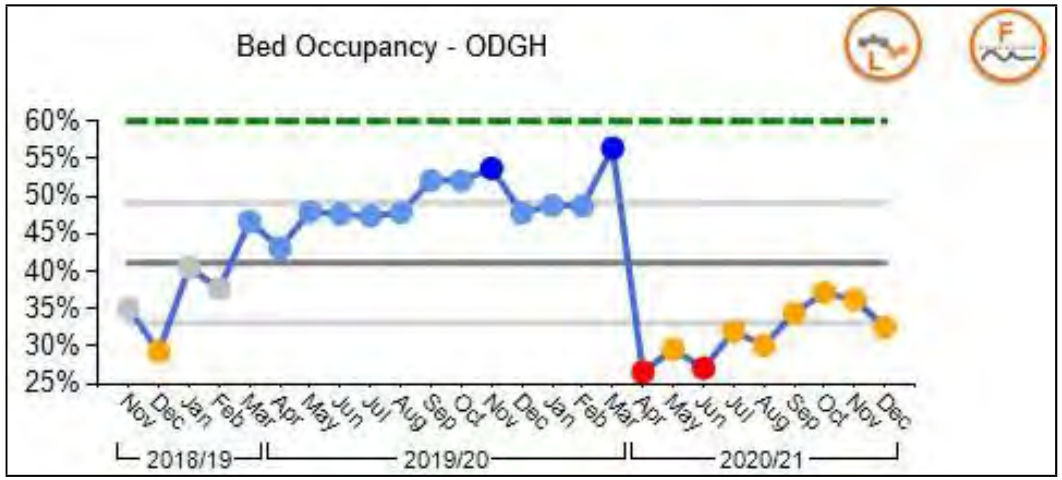
Mitigations:

- Additional scrutiny of theatre start times and underruns, being led by clinicians and monitored weekly.
- Continued monitoring of specialty level KPI's through the Theatre Efficiency meeting and reported into PIDA.

Bed Occupancy – ODGH

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%	32.5%	N/A	Dec 20		60%	36.2%	Nov 20	60%	31.7%	



Background: The bed occupancy figure is a ratio 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 & acute beds. Where beds are used for day case patients these are excluded from the occupancy figure which is taken as a midnight position 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 had increased slowly in-line with the Trust's ability to use theatres in accordance with increased infection control protocols. There has been a subsequent decline in occupancy in November and December.

Issues:

- Bed occupancy varies across wards at Ormskirk, the largest wards include E, G and H. These wards have now been reconfigured to provide elective care, GAB and emergency Gynae admissions (E), specialist Orthopaedic rehabilitation (G) and ring fenced Orthopaedic theatre patients (H).
- Inability to 'flex beds' in ODGH to account for nurse staffing, meaning the bed occupancy figures being reported are not reflective of the available beds, e.g. G Ward has 23 beds but only 14 of these are open.
- The Christmas period meant reduced elective/day case admissions with associated decrease in occupancy at ODGH. Activity was also impacted by Covid-19 in December, due to both patients and clinician's sickness/isolation.

Actions:

- Nursing staff management now have access to Medway to amend the bed numbers to identify open beds based on nurse staffing. This came into effect mid January, therefore the effect will be seen partially next month with the full effect evident from February's reporting.
- F ward (day cases) and H ward have been closed 2nd week in Jan in line with critical care escalation plan.

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.

Finance

Finance

Analyst Narrative:

Two indicators are failing the assurance measure; Distance from agency spend cap and % Agency Staff (cost). The reason Distance from agency spend cap is failing to provide assurance is due to historical performance pre 2020/21. The % Agency staff (cost) whilst showing failing assurance is showing positive variation, although an expected this has increased in December; the plan for this will remain a challenge throughout the winter period as the Trust faces high sickness/absence levels due to Covid-19. The pay run-rate, non-pay run rate and bank/agency run rate are all showing negative variation with significant increases in the Non-Pay Run rate in December. 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 was set for Months 7-12. The financial plan includes resource to fund additional expenditure for winter, activity restoration and Covid-19. The financial plan for Cheshire & Merseyside organisations continues to be unaffordable within the national position and the Trust has been asked to review the forecast outturn on a number of occasions with a view to providing an improved financial performance. The latest submission forecasts that a £1.3 million deficit is achievable in the "likely case" and, therefore, there is an expectation that this figure will be the new target for the year end (rather than the £1.7 million planned deficit).

Distance from Control Total – for the purposes of this report the Control Total is the Month 7-12 Financial Plan. As at December this measure is being achieved.

I&E Surplus or deficit/total revenue – a marginal deficit of -0.09% has been incurred in December. This was well within the December plan with the main issue being underspends within Urgent Care (COVID schemes and therapy vacancies). In addition, additional income has been received for spinal patients and funding for "lateral flow testing" which was in excess of costs. The Year To Date (YTD) plan is being achieved due to underspends in Quarter 3 as well as additional income.

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 November position. The funding of commissioning income one month in advance will be removed in March and the finance department is currently modelling the impact this will have on cash flow.

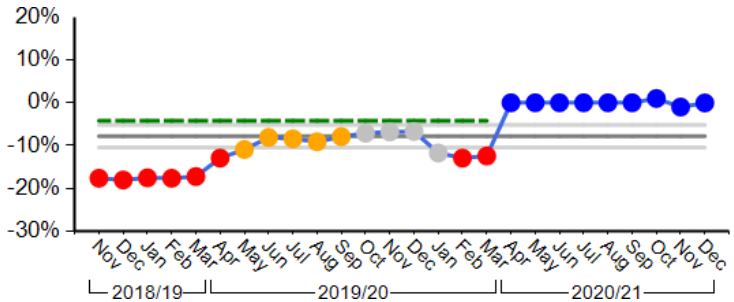
% Agency Staff Cost (%) – the increase in December reflects the additional agency spend being incurred within medical staff.
Capital service capacity –no material changes from November.

Pay Run Rate – November's spend reduced following the non-recurrent payment of Clinical Excellence awards in November. The run rate continues to be affordable within the Month 7-12 plan.

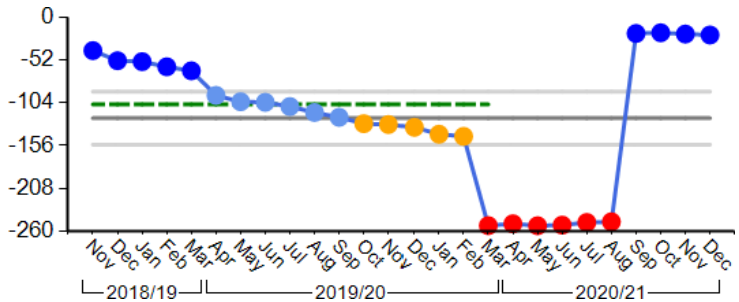
Non Pay Run Rate – November's run rate include a non-recurrent reduction of £0.1 million in depreciation. The run rate continues to be affordable within the Month 7-12 plan.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue		-0.1%	N/A	Dec 20	H	-4.2%	-1%	Nov 20		-0.1%	?
Liquidity		-22	N/A	Dec 20	H	-106	-21	Nov 20		-22	?
Distance from Control Total	0%	1.5%	N/A	Dec 20	H	0%	-0.8%	Nov 20	0%	1.5%	?
Capital Service Capacity		3.26	N/A	Dec 20	H	0.2	3.13	Nov 20		3.26	?
% Agency Staff (cost)	5%	7.6%	N/A	Dec 20	L	5%	6.8%	Nov 20	5%	7.8%	F
Use of Resources (Finance) Score	3	2	N/A	Dec 20	L	3	2	Nov 20	3	2	?
Distance from Agency Spend Cap	0%	0%	N/A	Dec 20	L	0%	0%	Nov 20	0%	0%	F
Pay Run Rate - Trust		£12,824K	N/A	Dec 20	H		£13,263K	Nov 20		£112,526 K	?
Non Pay Run Rate - Trust		£5,507K	N/A	Dec 20	H		£5,256K	Nov 20		£45,505K	?
Bank & Agency Run Rate - Trust		£2,306K	N/A	Dec 20	H		£2,456K	Nov 20		£19,447K	?

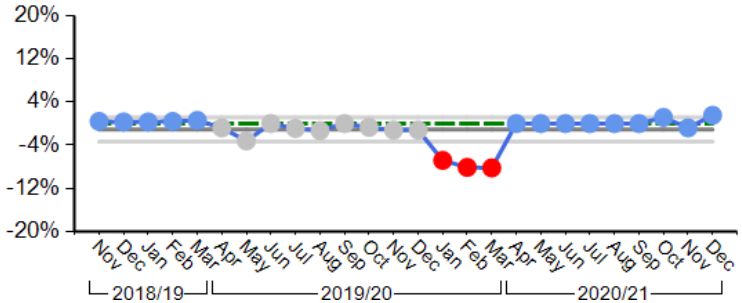
I&E surplus or deficit/total revenue



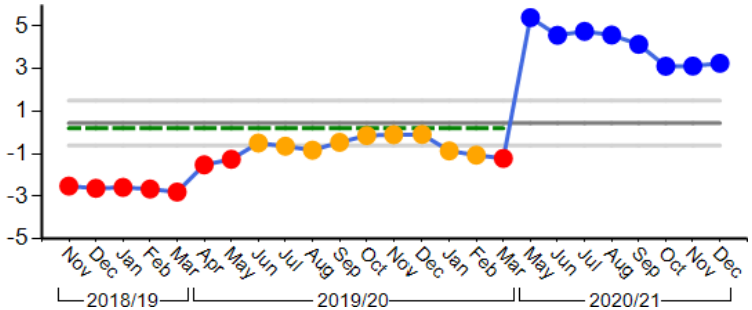
Liquidity



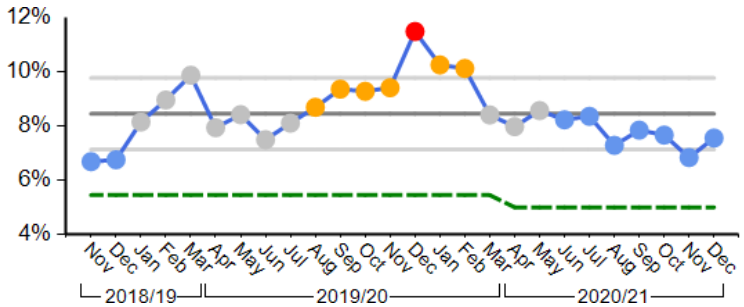
Distance from Control Total



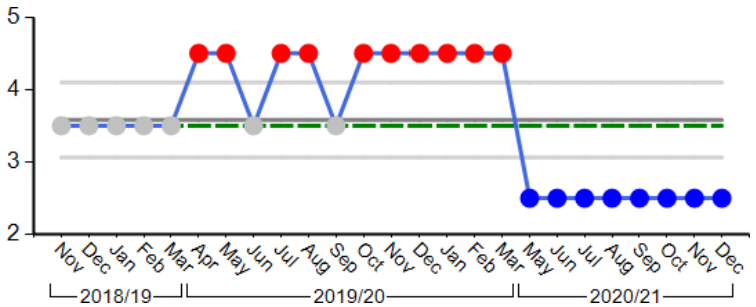
Capital Service Capacity



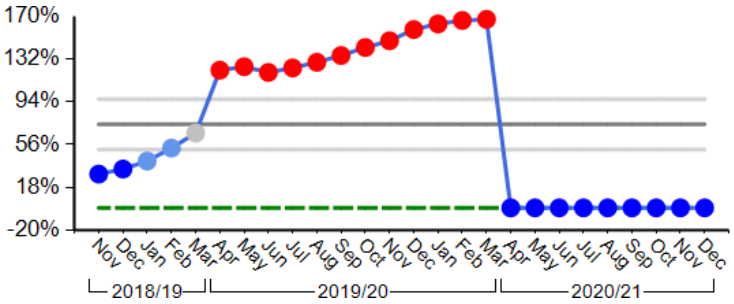
% Agency Staff (cost)



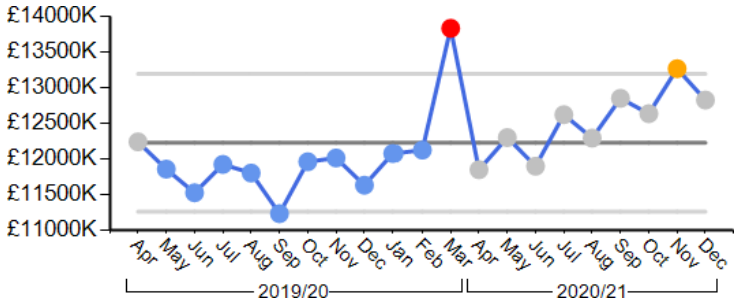
Use of Resources (Finance) Score



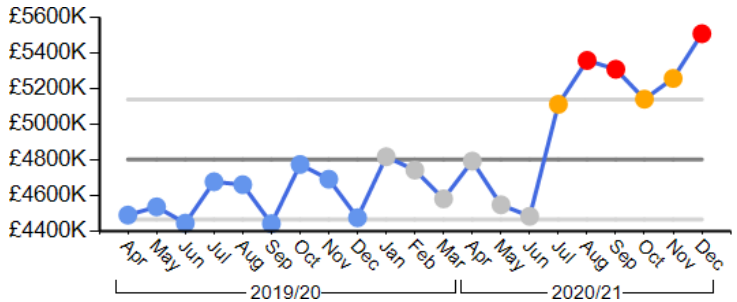
Distance from Agency Spend Cap



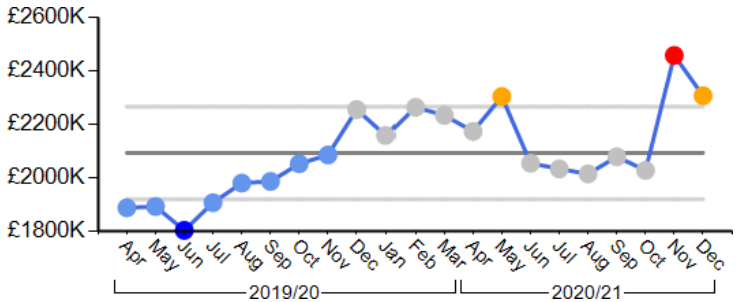
Pay Run Rate - Trust



Non Pay Run Rate - Trust



Bank & Agency Run Rate - Trust



NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB011/21**	**FOI Exempt**	**NO**
Report Title	**DIRECTOR OF FINANCE REPORT - MONTH 9 FINANCIAL POSITION**		
Executive Lead	Bill Gregory, Interim Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

This report provides the Board with a summary of the financial position as at December 2020.

Executive Summary

Lower expenditure and higher income than planned has resulted in an underspend of £361,000 year to date (YTD).

A significant element of the underspend is driven by underspends on winter and COVID schemes within Urgent Care.

The CIP Plan has recovered from the underperformance reported in November and is forecast to deliver.

The Trust has signalled to the Regulator on 6 January that a forecast of £1.3 million could be achieved, against the resource allocation made available. Whilst current expenditure run rates make this appear achievable, the likely position on annual leave carry forward and full recovery of non-NHS income are material risk to achievement.

The Trust had £18.4 million in cash at 31 December 2020 and there are currently no cash issues due to the continued prepayment of block contract from commissioners, although we have been notified that the contract pre-payment made in April 2020 will be clawed back in March, as such a detailed cash flow is being developed.

We now have formal confirmation that the current "Covid-19" financial regime will continue for the first quarter of 2021/22. However, it is expected that future funding allocations will largely be based on pre-Covid19 resource levels, which will likely present the Trust and its commissioners with ongoing challenges similar to pre-Covid-19.

Recommendations

The Board is asked to note the report.

Previously Considered By:

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

Strategic Objectives

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

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

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

Finance Report – Month 9 2020/21

1. Purpose

1.1. This report provides the Board with a summary of the financial position at month 9 (December) 2020/21.

2. Executive Summary

2.1. Lower expenditure and higher income than planned has resulted in an underspend of £361,000 year to date (YTD).

2.2. A significant element of the underspend is driven by underspends on winter and COVID schemes within Urgent Care.

2.3. The CIP Plan has recovered from the underperformance reported in November and is forecast to deliver.

2.4. The Trust has signalled to the Regulator on 6th January that a forecast of £1.3 million could be achieved, against the resource allocation made available. Whilst current expenditure run rates make this appear achievable, the likely position on annual leave carry forward and full recovery of non-nhs income are material risk to achievement.

2.5. The Trust had £18.4 million in cash at 31st December 2020 and there are currently no cash issues due to the continued prepayment of block contract from commissioners, although we have been notified that the contract pre-payment made in April 2020 will be clawed back in March, as such a detailed cash flow is being developed.

2.6. We now have formal confirmation that the current "Covid" financial regime will continue for the first quarter of 2021/22. However it is expected that future funding allocations will largely be based on pre-covid resource levels, which will likely present the Trust and its commissioners with ongoing challenges similar to pre-covid.

3. Income and Expenditure

3.1. The Trust submitted plans for a £1,712,000 deficit in year following discussions with the Regulator and Cheshire & Merseyside Health & Care Partnership (HCP).

3.2. The deficit is planned to be delivered in months 7-12 only as the Trust delivered break-even in the first half of the year.

3.3. There have been further discussions to improve the deficit position (latest forecast £1.3 million deficit) but the planned deficit remains the same (see section 10)

3.4. The table below is the I&E statement for month 9 which compares actual performance against Trust Budget for the second half of the year:

Table 1 Income & Expenditure for second half of the year– Month 9

I&E (Including R&D)	HALF YEAR M 7-12	M7,8,9			MONTH 9		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	90,640	45,300	45,380	80	15,100	15,220	120
PP, Overseas & RTA	374	187	177	(10)	62	43	(19)
Other Income	5,376	2,706	2,579	(127)	954	918	(36)
NHSE/I Top up	17,667	8,746	8,746	0	2,973	2,973	0
Total Operating Income	**114,057**	**56,939**	**56,882**	**(57)**	**19,089**	**19,154**	**65**
PAY	(81,181)	(39,823)	(39,641)	182	(13,535)	(13,203)	332
NON PAY	(32,368)	(16,375)	(16,166)	209	(5,495)	(5,609)	(114)
Total Operating Expenditure	**(113,548)**	**(56,198)**	**(55,807)**	**391**	**(19,030)**	**(18,812)**	**218**
Operating surplus/deficit	**509**	**741**	**1,075**	**334**	**59**	**341**	**282**
NET FINANCE COSTS	(2,221)	(1,110)	(1,117)	(7)	(370)	(372)	(2)
Retained Surplus/Deficit	**(1,712)**	**(369)**	**(42)**	**327**	**(311)**	**(30)**	**280**
Technical Adjustments	0	0	34	34	0	13	13
Break Even Surplus/(Deficit)	**(1,712)**	**(369)**	**(9)**	**361**	**(311)**	**(18)**	**293**

3.5. The Trust is ahead of plan and is break-even at Month 9 YTD.

3.6. Of the £361,000 favourable variance reported to date £259,000 relates to winter (£79,000) and Winter with COVID (£180,000) schemes.

3.7. The remaining £102,000 relates to other budgets and includes additional commissioning income.

3.8. The forecast outturn position is described in section 10.

4. COVID

4.1. In addition to the Winter with COVID schemes (3.6 above) the Month 7-12 plan allowed for expenditure of £3,028,000 for the continued costs of other COVID related expenditure into months 7-12 (£505,000 per month).

4.2. The Quarter 3 spend was £1.1 million which is well below the plan.

4.3. This is not generating an underspend at month 9 as the COVID spend of £1.1 million is funded from the reserve at month 12.

5. Expenditure

5.1. December's expenditure has reduced from November levels.

5.2. Month 8 contained non recurrent expenditure of £0.2 million on Clinical Excellence Awards and the expected reduction in run rate has not been replaced by additional expenditure.

5.3. The table below contains the budgetary performance by CBU and directorate:

Table 2 Budget Performance at Month 9 (December 2020)

Business Unit	Annual	Year to Date			In Month - Month 9		
	Budget	Budget	Actual	Var	Budget	Actual	Var
	£000	£000	£000	£000	£000	£000	£000
Urgent Care	(58,729)	(43,244)	(42,711)	533	(5,387)	(5,132)	255
Planned Care	(56,097)	(41,642)	(41,416)	226	(4,851)	(4,800)	51
Specialist Care	(35,102)	(26,064)	(26,122)	(58)	(2,964)	(3,063)	(99)
Corporate	200,285	151,252	150,786	(466)	17,095	17,241	146
Finance	(6,064)	(4,629)	(4,620)	9	(506)	(571)	(65)
Estates & Facilities	(17,074)	(12,880)	(12,828)	52	(1,397)	(1,410)	(13)
Human Resources	(3,044)	(2,275)	(2,332)	(57)	(256)	(247)	9
Nursing & Midwifery	(3,545)	(2,581)	(2,599)	(18)	(321)	(313)	8
Medical Director	(8,765)	(6,533)	(6,487)	46	(744)	(741)	3
Strategy	(8,526)	(7,832)	(7,792)	40	(610)	(610)	0
Financing Costs	(5,051)	(3,941)	(3,888)	53	(370)	(372)	(2)
Total	**(1,712)**	**(369)**	**(9)**	**361**	**(311)**	**(18)**	**293**

Note – the above table includes a small amount of income across all business units (except corporate which contains the majority of the Trust's income.

5.4. Urgent Care has delivered an in month underspend of £255,000 with £146,000 of the variance relating to a benefit on COVID and winter with COVID schemes. £55,000 of the underspend relates to therapy vacancies.

5.5. The Corporate underspend relates to over performance of income of which £70k relates to a spinal patient from Isle of Man. In addition, the Trust received £80,000 funding for "lateral flow" testing which incurred substantial less in expenditure.

5.6. Specialist Services has overspent (Maternity cots £25,000, Anti Retrovirals £17,000 and £20,000 admin & clerical agency).

5.7. Finance has overspent in month which is mainly due to an IT Capital to revenue transfer of ipad licences.

6. Income and Activity Performance

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

6.2. The table below illustrates the impact of COVID in the early part of the year and the increase in activity since month 4 as the Trust began to restore activity following the first wave of COVID:

Table 3 Activity and Income performance

PbR Activity & Income																				
	2019/20 Average		2020/21																	
			Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Oct-20		Nov-20		Dec-20	
POD Summary	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000
A&E	7,284	1,166	3,404	611	4,569	800	5,237	894	5,677	970	5,997	1,010	6,054	1,022	5,606	969	5,535	944	5,355	798
DC	1,701	912	436	194	453	206	657	348	1,049	550	1,051	550	1,311	746	1,338	746	1,304	748	1,174	613
DI	1,862	179	551	51	663	65	1,302	134	1,694	162	1,548	157	1,810	173	1,715	172	1,793	179	1,500	142
EL	175	504	32	93	41	110	44	89	91	235	111	296	124	337	174	437	163	380	137	399
NEL	2,838	5,358	1,626	2,546	2,053	3,284	2,223	3,931	2,287	4,667	2,094	4,340	2,201	4,546	1,952	3,920	2,060	4,021	2,013	4,026
OP F2F	10,196	1,151	2,275	269	2,505	311	3,767	448	5,891	680	5,988	695	7,753	897	8,118	915	7,715	895	7,070	805
OP NF2F	1,148	36	6,180	374	6,667	418	8,677	544	8,782	543	6,250	363	7,439	434	7,082	416	7,420	428	6,510	369
OPPROC	4,662	633	730	118	917	148	1,966	300	2,695	396	2,716	400	3,309	493	3,176	464	3,249	475	3,003	439
Grand Total	**29,866**	**9,939**	**15,234**	**4,255**	**17,868**	**5,342**	**23,873**	**6,689**	**28,166**	**8,202**	**25,755**	**7,811**	**30,001**	**8,647**	**29,161**	**8,038**	**29,239**	**8,069**	**26,762**	**7,591**

6.3. As expected we observed a reduction in both elective inpatient and day case activity in December 2020 compared to 2019/20 average and previous month's performance as a result of the festive period. However elective activity in month was circa 93% of December 2019 actual, whilst day case activity was at 71% of December 2019 level. This is compared to a target of 90% for both elective and day cases.

6.4. The Elective Incentive Scheme has been effective since September with overall performance and incentive monitored at a system level. The Trust is awaiting the outcome of discussions taking place nationally/system level with regards to the allocation of incentive monies and the possible temporary suspension of the scheme as a result of increasing COVID numbers.

6.5. Diagnostic Imaging performance is 81% against last year's average and 92% against December 2019 actual. The target for December 2020 being 90%.

6.6. Outpatient activity is over 100% of 2020/21 levels as a result of significantly increased non-face-to-face attendances which now account for around 50% of all contacts.

6.7. The Trust continues to perform well in its recovery of activity compared to local peers however the suspension of non-urgent elective activity in January 2021 will have a significant negative impact.

6.8. There is a small risk that due to the block nature of the contractual arrangements in Month 7-12 that any cost associated with activity performance over and above plan would not be off-set by additional income, especially if the system is under performing as a whole.

6.9. A&E and Non Elective activity continued to reduce in month 9 as a result of further COVID impact.

6.10. Total income for month 7-12 has been set in line with NHSE/I plan and consists of a core block, system growth monies and COVID funding.

7. Cost Improvement Programme

7.1. The table below shows the CIP Plan has over delivered in December.

Table 4 CIP Performance at Month 9

CBU	Revised CIP Target (CYE)	Actual M1-6 (CYE)	Revised Target M7-12 (CYE)	M9 Plan	M9 Actual	M9 Variance	Plan M7-9	Actual M7-9	Variance M7-9	Required M10-12
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Corporate	315	124	196	3	21	18	46	63	17	133
Estates & Facilities	27	4	23	4	4	(1)	12	16	4	8
Finance	116	-	114	4	-	(4)	6	3	(3)	111
Strategy	36	15	18	3	5	2	11	14	3	4
Nursing &Midwifery	96	57	39	7	6	(1)	19	16	(3)	23
Planned Care	368	104	264	25	24	(1)	76	73	(3)	191
Specialist & Support	144	37	107	18	35	17	54	56	2	51
Urgent Care	527	106	421	65	249	184	160	312	152	109
Total	1,629	447	1,182	129	343	215	384	552	169	630

7.2. Performance has improved in month and is overperforming year to date. The main improvement relates to Urgent Care and reduced premium agency expenditure.

8. Cash

8.1. The cash balance at the end of December was £18,382,000 which was very close to the forecast position of £18,397,000.

8.2. Cash balance remains healthy as the Trust is still being paid a month in advance by the main CCGs however, no receipts are expected in March to claw these advances back.

8.3. Public dividend capital of just over £2 million has been requested in January now that a number of capital schemes have completed.

8.4. As no commissioning funding is planned for March this may be a challenging month in terms of cash flow. A refresh of the cashflow statement is being undertaken as we receive more information regarding the proposed financial regime for 2021/22 and the expected income on cash.

9. Debtors

9.1. Overall debt has again reduced from £3.7 million last month to £3.6 million this month.

9.2. The debt reduction is on non NHS debt with NHS debt rising slightly, fuller details were presented at the FP&I Committee.

10. Forecast Outturn

10.1. Our original year end forecast to the Cheshire & Merseyside HCP was £1.7m overspend against allocation. This was improved on, following reviews prior to Christmas to £1.4m, and more recently to £1.3m following settlement of a number of out of area debts owing to the Trust.

10.2. The ICS position has also improved from a forecast overspend of £134m to £111m. There is an ambition to improve on this by another £11m, to get to what is regarded as an acceptable position of £100m overspent (following the impact of the 2nd wave in the North West).

10.3. There are three or four large Trust/CCG forecast overspends contributing to the adverse ICS position. A further refresh is required on 27th January as the HCP look to close the gap further. At the present time we don't envisage a further improvement in our forecast, which is very much contingent on the expenditure position for January as the COVID peak is anticipated to be reached.

10.4. We are in the process of producing a best/likely/worst case set of forecasts for the year end so we can track our position to a satisfactory conclusion. However, the carry over of annual leave

and the recovery of non-nhs income impacted by wave 2 Covid are currently being assessed, and could be material factors in achieving the current forecast.

11. Underlying Deficit

11.1. It was reported in July's F,P&I committee that the Trust's underlying deficit going into 2020/21, before any CIP or investments, was £35 million. There is no indication that the Trust's underlying deficit has improved since then although future income levels are unclear.

11.2. Early indications suggest that the 2021/22 contracting framework will not revert back to Payment by Results (PbR) and that a "blended tariff" arrangement may apply which may include previous funding applied non recurrently (Financial Recovery Fund and Provider Sustainability Fund).

11.3. The latest communications suggest that the system may be going back to an allocations based funding framework which would also incorporate the non recurrent elements from previous years such as Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF), with some allowance for the impact of Covid in terms of efficiency. This could leave the Trust with gap of c£15-17m, however as more information becomes available a set of scenarios will be developed of the future outlook.

11.4. The FP&I Committee considered a business planning paper, which suggested an approach to developing the plan and budget for 2021/22 using the combination of arrangements that are likely to be in place and different points in the year. However, the availability of details to inform this are likely to mean the budget is unlikely to be finalised until April.

12. Recommendations

12.1. The Board is asked to note the following:

- At Month 9 YTD the Trust is at break-even
- The Trust is forecasting a "likely" deficit" of £1.3 million, subject to review of risks associated with annual leave carry forward and recovery of non-nhs income
- Work has commenced on planning and budgeting for 2021/22, and we expect to be in a position to finalise it during April 2021.

Workforce

Agency

Analyst narrative:

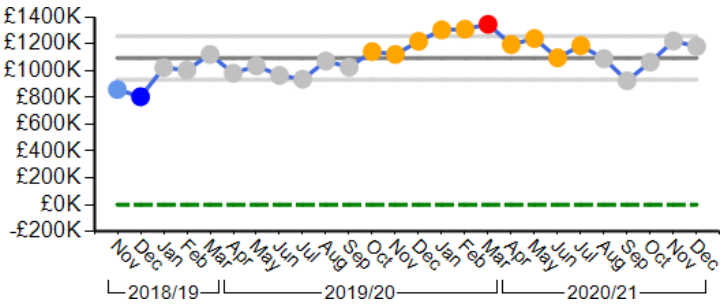
The Expenditure on Bank / Agency Staff is failing assurance although there has been a marginal reduction in December due to a reduction in bank costs.

Operational narrative:

Bank and agency spend – November experienced a significant increase in bank costs in Nursing and “Other Medical staff”. The increase in temporary spend is associated with the phasing of winter and “COVID with winter” schemes as forecast. The increase in nurse bank coincides with the nurse incentive scheme. Bank costs have reduced in December but still remain high as forecast. Total agency spend increased from £927,000 in November to £997,000 in December, mainly within medical staff.

	Latest					Previous		Year to Date		
					Plan	Actual	Period	Plan	Actual	Assurance
Indicator	Plan	Actual	Patients	Period	Variation					
Expenditure on Bank / Agency Staff	£00K	£1,180K	N/A	Dec 20			Nov 20		£10,191K	F

Expenditure on Bank / Agency Staff



Workforce

Organisational Development

Analyst Narrative:

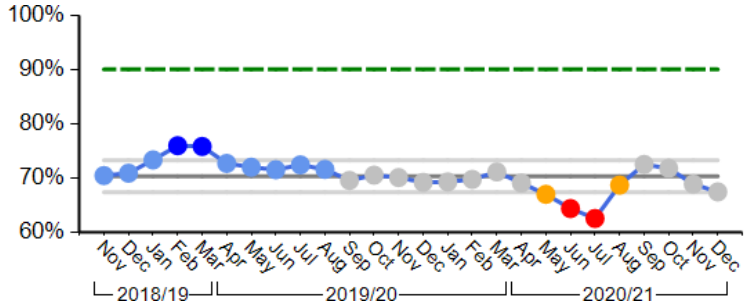
Personal Development Reviews remain a cause for concern with failing assurance and a further downturn in December. Further narrative/action is required to provide assurance. Mandatory training is now providing assurance as it continues to perform ahead of plan. This performance needs to be sustained. The Staff Friends and Family remains suspended due to Covid-19.

Operational narrative:

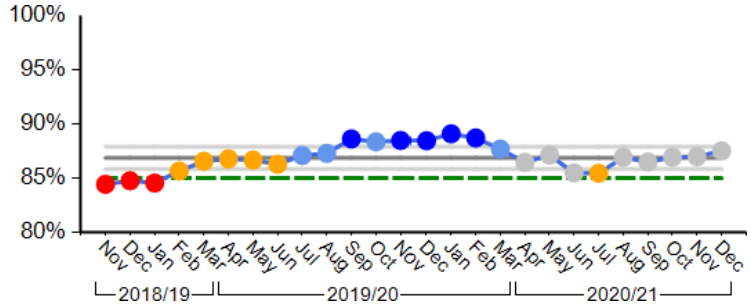
See supplementary action plan for PDR's.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	90%	67.5%	N/A	Dec 20		90%	68.9%	Nov 20	90%	68.9%	F
Mandatory Training	85%	87.5%	N/A	Dec 20		85%	87%	Nov 20	85%	86.6%	P
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%	?

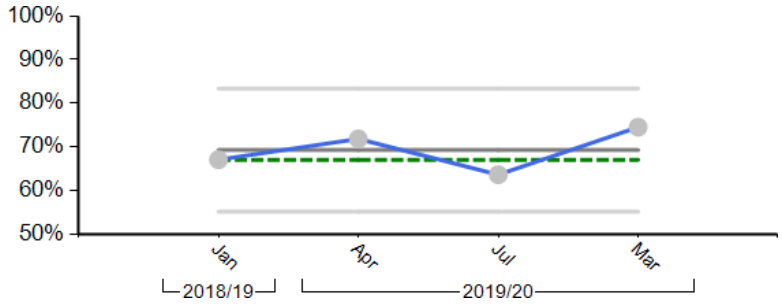
Personal Development Review



Mandatory Training



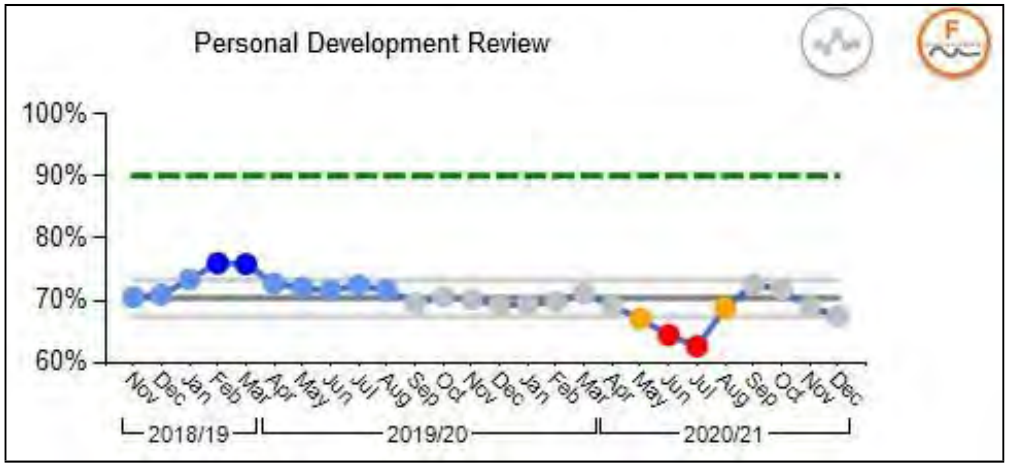
Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall



Non-Medical Appraisal/Personal Development Reviews

Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Personal Development Review	90%	67.5%	N/A	Dec 20		90%	68.9%	Nov 20	90%	68.9%	



Background: The annual appraisal/PDR is an AfC requirement for all non-medical staff at the Trust and from April 2021 will be linked to pay progression. The Trust has a 90% compliance target and they form part of the Trust's performance framework and are monitored at PIDA. Appraisals are an indicator of overall staff engagement and form a crucial activity in the management of human resources

Situation: The Trust has consistently under-performed over the last 3 years, achieving between 60-75% appraisal compliance thereby failing to miss the 90% target. The Trust generally has its highest performance throughout the Spring and Summer months with a consistent deterioration in compliance throughout the winter months. The Trust falls below the national average for the quality of appraisals in the annual NHS Staff Survey

Issues:

- Poor definition of the purpose of appraisals at the Trust
- Poor management appraisal skills
- Poor documentation and process
- Lack of consistent recording impacting on the quality of data
- No quality assurance mechanism in place

Actions:

- Appraisal deep dive analysis undertaken from Sept to Nov 2020
- Recommendations paper presented at Workforce Committee 15/12/2020
- Project Lead identified to prioritise recommendations and develop an action plan by end of February 2021.

Mitigations:

- MIAA Audit undertaken Nov-Dec 2020

Workforce

Sickness, Vacancy and Turnover

Analyst Narrative:

7 indicators are currently failing to provide assurance, relating to sickness, turnover and vacancy rates. The rolling sickness rate is showing negative variation due to the continued impact of Covid-19, although the in-month position has decreased slightly as the Trust recovers from the second wave of Covid-19. The rolling staff turnover continues to be impacted by the spike in August as the in-month position has improved significantly and is ahead of plan.

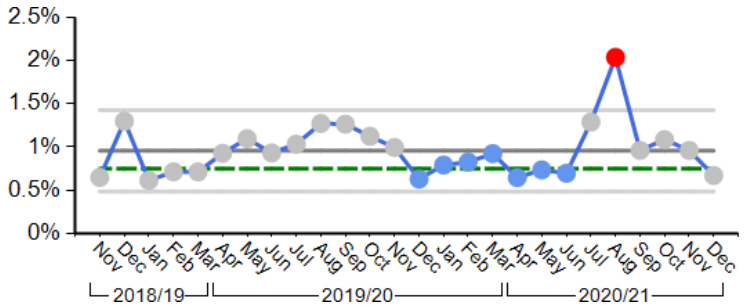
Operational Narrative:

With the current third wave of covid-19, it is essential that non-Covid-19 related absence is managed as effectively as possible to mitigate the impact on workforce numbers over the coming months. An in-depth analysis of absence has helped inform targeted actions to reduce it further and highlighted long term absence is particularly high at this Trust compared to the proportion expected elsewhere. 'Anxiety /stress / depression /other psychiatric illnesses' are the main reason for absence for both short and long term absence, and Covid-19-related absence is emerging as a common reason amongst long term absence, particularly amongst nursing and healthcare assistant staff groups. There are no uncertainties about the impact the current crisis is having on staff and the absence data illustrates this. Whilst there are some immediate and tactical actions identified to support a return to work for those currently absent from work, there will be a renewed focus on improving the overall morale of the workforce at this challenging time and putting in place support to mitigate the longer term impact of the pandemic on our staff. Examples include leadership support, proactive resource planning, assistance to staff to develop coping strategies and debrief on their experiences to date.

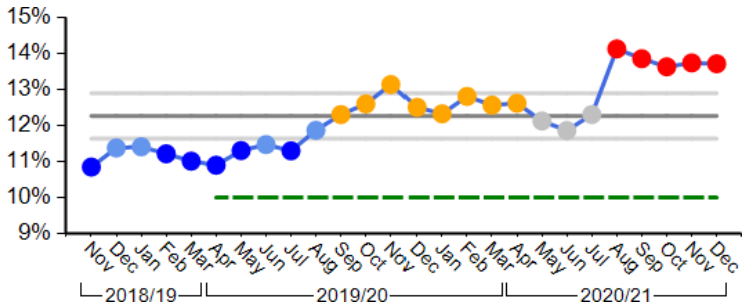
Recruitment activity for nursing continues as planned and in terms of medical recruitment, the Trust is improving its branding and strengthening its relationship with recruitment agencies, which is already showing positive results. An in-depth review of the time to hire process has identified some immediate improvements, and already resulted in an encouraging reduction in time to hire.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Staff Turnover	0.75%	0.7%	N/A	Dec 20		0.8%	1%	Nov 20	9%	6.8%	?
Staff Turnover (Rolling)	10%	13.7%	N/A	Dec 20	H	10%	13.7%	Nov 20			F
Vacancy Rate - Medical	5%	9.8%	N/A	Dec 20		5%	10.2%	Nov 20	5%		F
Vacancy Rate - Nursing	8%	15%	N/A	Dec 20	H	8%	15%	Nov 20	8%		F
Sickness Rate	4%	6.2%	N/A	Dec 20		4%	6.8%	Nov 20	5%	6.4%	F
Sickness Rate (Rolling 12 Month)	4%	6.3%	N/A	Dec 20		4%	6.2%	Nov 20	4%	6%	?
Time to Recruit	55	45	N/A	Dec 20		55	51	Nov 20	55	54	?
Sickness Rate - Medical Staff	4%	2.9%	N/A	Dec 20		4%	3.3%	Nov 20	4%	3.3%	F
Sickness Rate - Nursing Staff	3.7%	7.9%	N/A	Dec 20		3.7%	8%	Nov 20	3.7%	8%	F
Sickness Rate - Non-Clinical Staff	4%	5.1%	N/A	Dec 20	H	4%	5.8%	Nov 20	4%	5.7%	F
Sickness Rate (not related to Covid 19) - Trust	4%	5.2%	N/A	Dec 20		4%	5.5%	Nov 20	4%	4.8%	

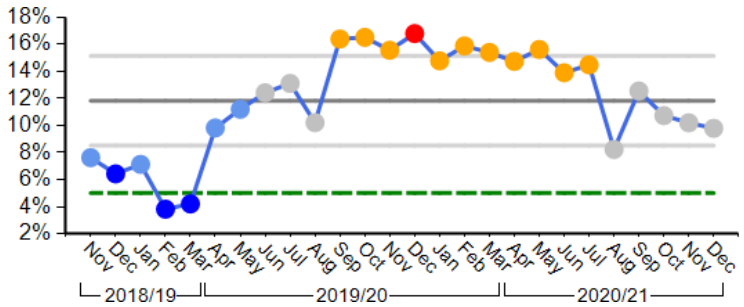
Staff Turnover



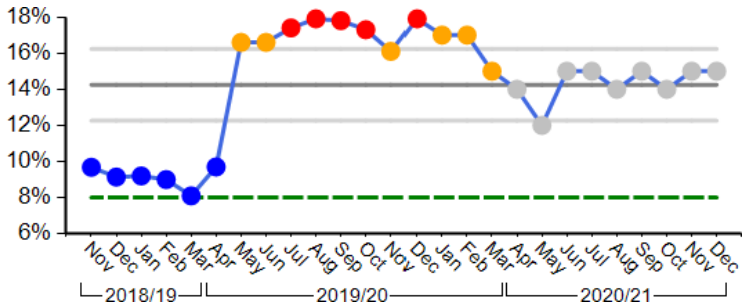
Staff Turnover (Rolling)



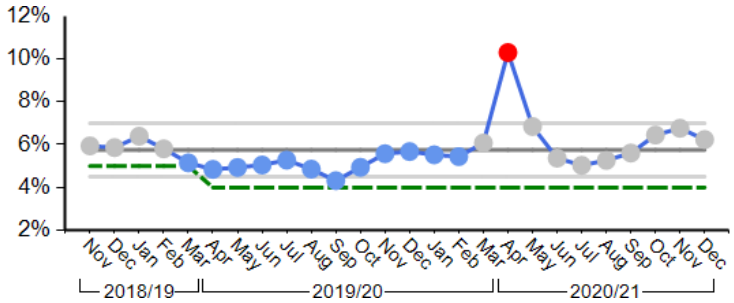
Vacancy Rate - Medical



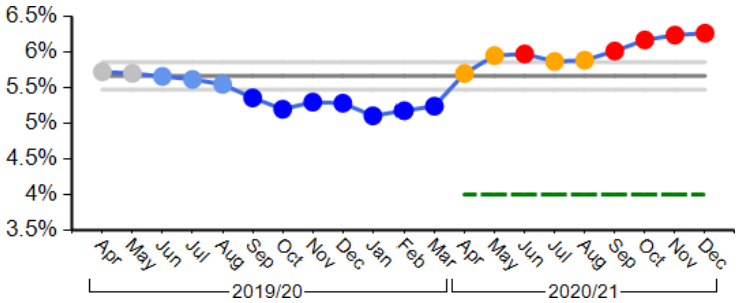
Vacancy Rate - Nursing



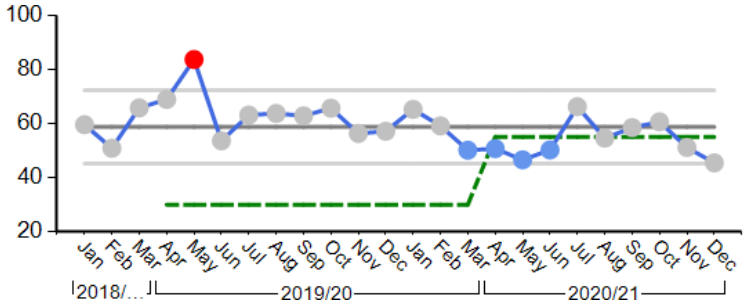
Sickness Rate



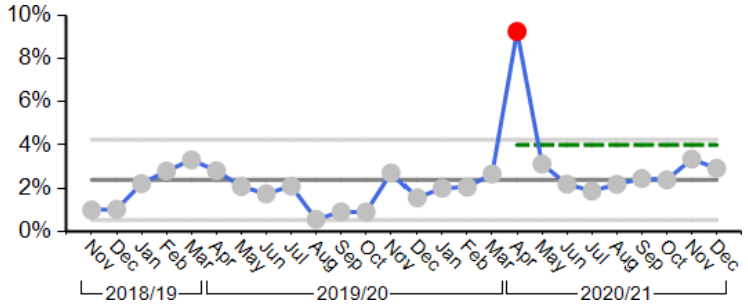
Sickness Rate (Rolling 12 Month)



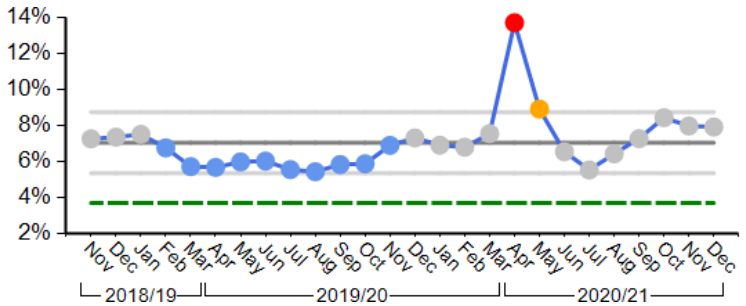
Time to Recruit



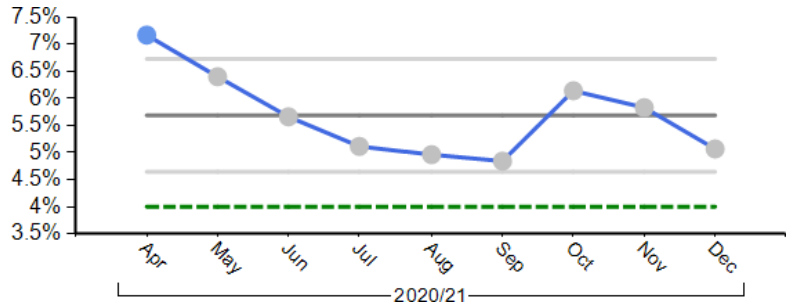
Sickness Rate - Medical Staff



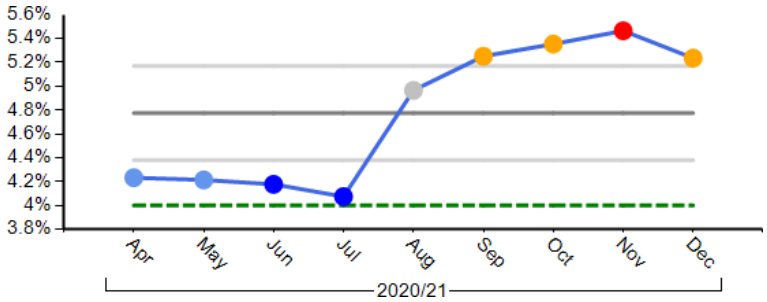
Sickness Rate - Nursing Staff



Sickness Rate - Non-Clinical Staff



Sickness Rate (not related to Covid 19) - Trust



ALERT, ADVISE, ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP	**WORKFORCE COMMITTEE**
MEETING DATE:	**26 JANUARY 2021**
LEAD:	**PAULINE GIBSON**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence
Whilst the sickness absence rates for the staff groups within the organisation have all reduced in month, the rolling 12 month figure has increased by 0.1%, detailing that the improvements aren't showing anything statistically meaningful. The HR Business Services team are continuously working hard to redeploy staff into areas of higher sickness to manage operations.

ADVISE

PDR Deep Dive - MIAA assurance
The PDR Deep Dive was approved at December's Workforce Committee before being signed off by the Audit Committee. The report has now been returned to the Executive Team for onward ownership and action planning. The plan will return to the Committee.

Core Mandatory & Role Specific Training
The Core Mandatory & Role Specific Training report presented to the Committee was not discussed in detail, similarly to Quality and Safety Committee (QSC) on 25th January 2021. The Committee were assured that the QSC are monitoring data on a ward by ward basis.

Medical Vacancies
The medical vacancy rate reduced from 10.2% in November 2020 to 9.8% in December 2020. There is a focus on our branding which is resulting in the attraction of good candidates and strong recent appointments. Efforts to further improve our attraction and retention continue.

ASSURE

Equality Diversity & Inclusion (ED&I) Annual Report 2019-20 and Equality Objectives
The Committee commended the ED&I annual report and work. From a poor start point we have made huge strides forward in compliance. It was agreed that the focus of ED&I will be to integrate within the People Plan and Patient Experience Strategy. The ongoing focus and commitment at Board and ETM will be defining our bold statement and 'living and breathing' our aspirational outcome.

MIAA Audit Mandatory Training
The MIAA Audit on Mandatory Training reporting provided substantial assurance. The Committee noted the great achievement in this outcome and stated the next steps are to implement the processes. The Board are asked to note the audit relates only to training records.

Commendation for Workforce Directorate
The Committee commended the Workforce Directorate for their efforts during the pandemic related to all people processes: Health & Wellbeing, Redeployment, supporting staff who have been shielding and those who haven't.

International Recruitment
The Committee were informed that 18 further nurses from India arrived on 22nd January 2021 and 12 more nurses are due to arrive in three weeks' time. This is a positive achievement in these times of challenge for International travel.

New Risk identified at the meeting:

- No new risks were identified at the meeting.

Review of the Risk Register

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB013/21**	**FOI Exempt**	**No**
Report Title	Our People Plan – Workforce and OD Strategy		
Executive Lead	Jane Royds, Director of HR & OD		
Lead Officer	Sonya Clarkson, Deputy Director of HR & OD		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To agree the Trust's Workforce and OD Strategy ('Our People Plan') and the Trust's people priorities for the next two years.

Executive Summary

Our People Plan describes how we will support our staff to *recover* from our response to the pandemic, *reset* to a post-Covid 19 world and *cope with changes* in demand and delivery of services to patients across Southport and Ormskirk. At the same time, ensuring that staff feel empowered, valued, developed, trusted and motivated to move towards the future, embracing change and the introduction of technology and new ways of working and endeavouring to improve the quality of care they provide.

This plan has been developed in line with the ambitions of the national NHS People Plan that we need more people, working differently, in a compassionate and inclusive culture. It is designed to be flexible enough to respond to the lived experience of our staff and our shared hopes for the Trust over the next two years.

Divided into four key areas of focus, Our People Plan sets out what we need to do, together, to ensure everyone is able to thrive within the NHS community.

The delivery of Our People Plan will affect every one of our colleagues, and it's impact will be monitored by the Trust's Workforce Committee. Enabling strategies will be developed providing further detail on the delivery plans for each of the four key areas of focus.

Recognising diversity is an impact of an inclusive culture, we will identify key workforce indicators to monitor our progress we are making against Our People Plan. These will be reported on a quarterly basis to the Trust's Workforce Committee.

'Measures of success' need to be aligned to the regional People Plan and those to be determined by the Board in relation to the Inclusion Agenda. So will be developed once these are available and the C&M People Board have shared their intentions for measuring the performance and impact of the regional People Plan.

Recommendation

The Board is asked to **approve** the Trust's People Plan, subject to further work required on developing the metrics.

Previously Considered By:

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

Southport and Ormskirk Hospital NHS Trust

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

Southport and Ormskirk Hospital NHS Trust

Our People Plan

Introduction

Our People Plan describes how we will support our staff to *recover* from our response to the pandemic, *reset* to a post-Covid 19 world and *cope with changes* in demand and delivery of services to patients across Southport and Ormskirk. At the same time, ensuring that staff feel empowered, valued, developed, trusted and motivated to move towards the future, embracing change and the introduction of technology and new ways of working and endeavouring to improve the quality of care they provide.

This plan has been developed in line with the ambitions of the national NHS People Plan that we need more people, working differently, in a compassionate and inclusive culture. It is designed to be flexible enough to respond to the lived experience of our staff and our shared hopes for the Trust over the coming years.

Divided into four key areas of focus, Our People Plan sets out what we need to do, together, to ensure everyone is able to thrive within the NHS community.

The delivery of Our People Plan will affect every one of our colleagues, and it's impact will be monitored by the Trust's Workforce Committee.

The story so far

Like all NHS services across the country, we face significant challenges. Some challenges have been with us for years while the urgency of others has been exposed during the Covid-19 pandemic. We need to redefine how we provide hospital services, make them fit for the future and ensure they are safe, sustainable and high quality.

As the Trust seeks to determine what the future looks like, it needs to continue to operate and adapt in a changing, more complex and uncertain external environment, and stay true to its values.

The choices we are making

To achieve services fit for the future, the Trust is working with partners on a programme called 'Shaping Care Together' to look at service transformation as a whole and not as separate parts. This is because we know that working together means a better, more joined up and efficient service that delivers better outcomes for patients.

As people who deliver health and care services, our staff understand best what works well now and what needs to be changed to make our system a better place to work and improve outcomes for our patients and service users. Recognising the important role staff play, the Trust is committed to listening to the views of our staff, so we can shape care together.

Our workforce challenge

As a Trust, we face significant challenges, specifically around our ability to attract both medical and nursing staff. The Trust has one of the highest nurse vacancy levels in the UK, limited success in generating a pipeline of nurses and doctors following placements and a high number of Consultant vacancies in notoriously difficult to recruit to specialties.

Consequently, this has a direct impact on our locum and agency spend, and the lack of experienced staff has a knock on effect on the quality of placements, resulting in a perpetuating cycle of poor attraction of staff to the Trust.

As the Trust starts to engage with staff and the public on the 'Shaping Care Together' programme, there is a refreshed opportunity to work in partnership with others and redefine how we provide hospital services, make them fit for the future and ensure they are safe, sustainable and high quality. We want to keep services as local as possible, where it is appropriate, and keep our focus on the delivery of the highest quality clinical care provided by the range of excellent professionals we have working in our local hospitals.

It is also important that we acknowledge that for many staff COVID also brought personal sadness and suffering with the loss of friends, loved ones and colleagues and that our Black Asian Minority Ethnic (BAME) workforce suffer a disproportionate impact of the virus and that the consequences of this will be felt for many years to come. We must therefore ensure that we have the appropriate support for physical and mental health and wellbeing of our staff and ensure our staff continue to feel valued for the work that they do.

Our workforce

The diversity of our workforce is a key indicator of an inclusive culture. The effectiveness of line managers and their teams in setting the right cultural and behavioural tone by celebrating difference, empowering others to make their own unique contribution, and actively listening and then taking supported action cannot be understated.

As a progressive and inclusive Trust, we will regularly review key workforce information as a commitment to continuously improving and strengthening our community, and be accountable for the commitments we have made.

Our People Plan

The fundamental purpose of Our People Plan is to identify the Trust's people priorities for the next two years and to ensure that everyone connected to the Trust understands the contribution they make.

Due to the significant challenges faced by the Trust, there are a number of people priorities, with specific emphasis on the culture and behaviours we are working towards over this period.

Whilst this is a two year strategy, it sets the time for transformational change during this period and beyond. This overarching strategy is aligned to the NHS People Plan and will be supported by detailed annual plans covering key aspects of the four enabling pillars identified below:

1. Looking after our people

2. Belonging to the NHS
3. New ways of working and delivering care
4. Growing for the future

Board Assurance Framework

The Board Assurance Framework (BAF) provides a structured process which is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact on the delivery of the strategic objectives. Our People Plan is the 'golden thread' running through the BAF to support the delivery of the Trust's strategic objectives outlined below.

Strategic Objectives	Our People Plan - Key Deliverables
SO1 - Improve Clinical outcomes and patient safety to ensure we deliver high quality services	**Looking after our people** Staff health and wellbeing Staff engagement and communication People management practices **Belonging to the NHS** Promoting inclusion Improving our leadership culture **New ways of working** Agile and digital working Workforce planning Change management **Growing for the future** Workforce Recruitment and Retention
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	

Our underpinning approach

As the world changes following the pandemic, it has become even more important to ensure our staff feel supported during these continuing uncertain times.

Our decisions, actions and behaviours should be led by clear principles, particularly in times of significant change. Policies and procedures provide boundaries but can never be sufficient in and of themselves. This is why our SCOPE values and Just and Learning principles will provide a pathway to good decisions, regardless of the context in which those decisions are being made, so staff feel empowered to use their knowledge, skills and in the moment insights to innovate in real-time.

Along with our SCOPE values, the principles of a Just and Learning culture run as threads throughout everything we do. This fosters a sense of belonging, promotes a culture where every voice is heard and an environment where all people are valued for who they are.

During the pandemic, the Trade Unions have supported the Trust and their members to ensure staff were safe and that they had appropriate support for their health and wellbeing. We will continue to develop an open, honest and transparent relationship with our trade union colleagues, and welcome the support and challenge of our Trade Unions in implementing this strategy. We commit to the principles of a Just and Learning culture and through partnership working will ensure that we conduct business in a manner that is true to the Trust's SCOPE values.

SCOPE Values and Behavioural Framework

We pride ourselves in our five core SCOPE values that form the foundation of all that we do. These are:

Supportive *Working together and valuing each other for the benefit of patients*

Caring *Caring for our patients as indvidiuals, safely and with compassion*

Open and Honest *Acting with the highest standards of integrity, behaviour and accountability*

Professional *Asprigin to be the best in everything we do*

Efficient *The best quality care within the resources available*

Each of the values is accompanied by a set of behaviours which were developed by staff from across the organisation, guiding us on how we should appropriately deliver services and related to one another.

All staff will sign up to the Staff Charter, making a personal and team commitment to live up to our values we can ensure our services meet and exceed the expectations of our patients.

Principles of a Just and Learning culture

Accepting that we will provide safer care and be a healthier place to work if we are a learning organisation, the Just and Learning culture is centred on creating an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed.

We will build a culture where individuals feel able to speak up, offering different levels of access (e.g. freedom to speak up guardians) and ensure that when they do speak up, they are fully supported within the organisation.

These principles ensure we will:

- Have processes in place to support staff to help them work safely;
- Be accountable by holding ourselves to open and honest dialogue, where we share experiences and learning, and take personal responsibilty for making changes for the future safety of staff and patients;
- Be curious, always wanting to understand why and continuously improve by optimising behaviours and processes;

- Be respectful, civil and kind, and know where the line must be drawn between acceptable and unacceptable behaviours;
- Support swift resolution of issues and concerns, with timely access to support and feedback on decisions.

With the above principles in place, it provides an excellent foundation to optimise staff wellbeing, helping to build individual resilience to deal with the challenges life brings, to create a safe working environment where every person can make a positive contribution and take personal responsibility to deliver high quality care to patients.

The four enabling pillars

Our People Plan is based on four key areas of focus that aim to support the next phase of the Trust's transformational journey.

1. LOOKING AFTER OUR PEOPLE

Our aim

To keep our staff safe, healthy and well – both physically and psychologically – and improve their work experience. We act on feedback and as a result, our staff feel listened to, empowered to make a difference and valued for their contribution.

Key programmes of work

- **Staff health and wellbeing**

  Occupational heath and wellbeing will continue to 'Making Every Contact Count', and in addition to the national and regional health and wellbeing offers, we will continue to offer a wide range of health and wellbeing support packages for staff. All staff will have a wellbeing conversation to ensure everyone has the necessary support in place for them, and provides an opportunity to have a discussion about their lived experiences to help us improve.

- **Internal communication**

  Together, we will identify and deliver diverse channels of staff communication that engages staff in the shared goal, enables quality two-way internal dialogue and gives staff the opportunity to shape and deliver services. These will be a combination of presentational, written and on-line channels.

  Recognising our staff are passionate, proactive and committed, a weekly communications round-up is one example of how we will keep staff up to date, so everyone understands the purpose of their work and where their contribution fits with the Trust's strategic objectives. We will also improve the quality of access to key information for staff within the Trust, in particular the staff intranet and the role it plays in strengthening staff engagement.

- **Staff engagement**

  We recognise that high engagement does not necessarily equate to high wellbeing. So we will ensure there is balance in providing opportunity for high engagement, workforce wellbeing and continuous development by facilitating open dialogue across the Trust in a variety of ways. Using

the annual staff survey, quarterly friends and family test and regular pulse surveys, we will also check in with staff on how supported, listened to and valued for their contribution staff feel, taking prompt action in response.

We also know how important internal networking events are in encouraging cohesion and enhancing both staff and patient experience by bringing everyone together. We will continue to host engagement events, such as 'Big Brews' and various staff networking groups will be promoted as great opportunities for sharing ideas and learning from each other.

- **Staff opinion survey**

  We will actively seek the opinions of our staff and use appropriate, flexible evidence based methods of doing so. Leaders at all levels will be accountable for taking the necessary action to address any issues arising from staff opinion surveys, guided by our wellbeing and inclusion principles, and maximizing opportunities to reflect, enhance and co-create action plans with their teams. Staff will also be encouraged to take personal ownership for their own areas for development and actions they can take to have a more fulfilling time at work.

- **Celebrating success and recognising contribution**

  Our Trust recognition events help us to celebrate the culture and successes we have achieved together. Through the series of celebrations throughout the year such as such as 'Time to Shine' and 'SO Proud' awards, we will continue to provide the space to reflect on both the challenges and successes of the year.

- **Listening Plan**

  We will ensure that our staff have appropriate mechanisms to speak up safely and we will seek to understand how staff feel at moments that matter to them. We are committed to hearing the experiences of all our leaders and staff, and will roll out the Schwartz Rounds and 'Back to the Floor' approaches to improvement. Where formal processes do not currently exist to help hear the experiences of our staff, we will work to identify suitable measures and mechanisms to do so.

- **HR Policy Development Framework**

  We live our values through our practice and decision making processes, so our values will be embedded in our HR policies and will be guided by our underpinning principles. We will ensure we have up to date policy advice across all the HR categories, all in one place and in an accessible format. An annual policy development framework will ensure we review our practices regularly, seeking external expertise and benchmarking against our comparators to assure our approaches are best in class.

- **Development of people management competencies**

  We will deliver bespoke 'bitsize' development sessions for people managers to enable them to better support and enable high levels of performance, attendance and staff wellbeing. The first of these sessions will focus on induction and appraisal.

Operational oversight group

- **Valuing Our People Group**

  This group will monitor staff feedback through the annual staff survey and quartley staff, friends and family test results, analysis of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, regular feedback from Trade Unions, Staff Networks and analysis of data on turnover and sickness as measures of staff satisfaction. We will use these valuable insights to inform our people practices and help us understand the impact we are making. Most importantly, we will listen to the lived experiences of our staff through this forum, to assure ourselves that the experience had by all colleagues is equitable, inclusive and supports wellbeing in the workplace.

2. BELONGING TO THE NHS

Our aim

To work together to promote a culture where everyone feels they belong and ensure all forms of discrimination are not tolerated. We aspire to be recognised for positively promoting and delivering inclusion for all groups in our leadership, our workforce and in the way that we carry out our work. Recognising the disproportionate impact covid has had on certain groups, our commitment to improve inclusion for staff with protected characteristics will be one of our main priorities.

Key programmes of work

- **Promoting inclusion**

  We will do more to raise awareness of, and in tackling inequalities by promotion of cultural awareness and understanding through a Trust Diversity calendar of events, observing religious, holy days and festivals together, engaging with national and international days of importance, and supporting key campaigns such as Transgender Awareness Week, Black History Month, World Menopause Day, Disability Awareness Day and Hate Crime Awareness Week.

- **Anti Racism / Active Bystander training**

  The provision of Active Bystander training to enhance confidence amongst staff around identifying and dealing with hate crime incidents and micro-aggressions as positive upstanders. Diagnostic work around staff inclusion networks will provide us with valuable information around the expansion of our staff inclusion network groups in 2021-22.

- **Staff Network Health and Wellbeing Hub**

  Using the £50,000 grant from NHS Charities Together, we will establish a Staff Network Health and Wellbeing Hub to provide support to staff with protected characteristics and who have been disproportionately affected by Covid-19.

- **Improving our leadership culture**

  Our leaders play a key role in shaping the culture of the Trust and need to focus on developing a positive, inclusive and people-centred culture that engages and inspires all our people, and advances equality of opportunity. We will support our leaders to develop supportive and restorative

practice, eliminate unjust practices and seek to understand the lived experiences of others. By investing in the development of our leaders, we will strengthen clinical and operational management across the Trust, and build the capacity and capability required to deliver transformation.

We will continue to develop our leaders through our apprenticeship offer and provide access for managers to online development modules. We will maximise our NHS Leadership Academy membership and encourage all leaders to undertake a reflective 360 appraisal. We will also introduce a reverse mentoring programme, for our more experienced senior leaders to hone and refine their established leadership practices based on feedback, discussion and open dialogue with junior team members.

A coaching culture is integral to delivering our leadership approach and this will be supported by an in-house coaching network and access to external coaches and mentors through the NHS Leadership Academy.

- **Succession planning**

We aim to take a more strategic approach to identifying, nurturing and developing people to take on progressively greater responsibility and leadership within the NHS. Our approach to talent and succession management will be underpinned by our apprenticeship offer to Masters Level and encourage greater diversity for those being considered for director, senior manager or board level appointments and the Trust will be encouraged to look wider in their search for more diverse leadership.

Strategic Advisory Group

- **Strategic Advisory Group**

We will establish a group of individuals from diverse backgrounds who will meet on a quarterly basis to act as the Strategic Advisory Group for the Board on the actions needed to effectively address the challenges and issues faced by our staff and wider communities. This group will model the environment we want to create across the Trust, where we will constructively challenge one another and sometimes engage in uncomfortable conversations that enable us to arrive at better decisions for our staff and our communities. It is our intention that a member of this group will also sit on the North West Assembly which has a role in advising the Regional Management Team.

3. NEW WAYS OF WORKING AND DELIVERING CARE

Our aim

To make the best use of the full range of our people's skills, experience, knowledge and flexibility to deliver the best possible patient care in multi-disciplinary teams, maximising the potential of technology and agile working.

Key programmes of work

- **Agile working**

We want to encourage a way of working where our staff feel empowerd to work when and where it is appropriate for the services they provide. We will promote a culture of working that is explicitly supportive of agility in every aspect of the Trust – with maximum flexibility and minimum constraints – to optimise performance and enable rapid change in order to deliver the best possible patient care.

- **Digitial programme**

  We aim to develop the workforce digital capabilities of all our staff to enhance digital communication, improve problem solving and be prepared in a constantly evolving landscape. We want patients to benefit from more innovative delivery of care, where access to services is more flexible and accessible for them, and staff to embrace the opportunities working more agile brings.

  We will work in partnership with others to look at our systems and technology, and explore how roles and systems can best use latest technology and share best practice.

- **Workforce Systems Development**

  We will look at how we can optimise the use of the Electronic Staff Record, which will impact on data quality, accurate sickness absence data and help facilitate the movement of NHS staff, allowing greater flexibility of the workforce.

  We aim to provide both managers and staff greater control and flexibility to manage everyday HR activities, such as booking leave, recording absence and maintaining performance development reviews through a self-service portal.

  We will strive to fully implement rostering and job planning systems across the Trust, which will empower Clinical Managers to make informed decisions based on skills and competencies, patient acuity and demand, ensuring we can deliver the highest quality patient care, whilst working to reduce the need for contingent labour.

- **Online learning briefings and toolkits**

  We will continue to develop a range of online learning opportunities for staff to complete at any location, at any time, enabling a more flexible approach to delivery. Utilising technology efficiently and effectively will help enhance the staff experience.

- **Workforce movement and joint appointments**

  Building on the agreement in place across Cheshire and Merseyside to facilitate the movement of staff across organisations, we are now in a position to look at mutual aid with our colleagues in other Trusts, social care and the wider care home sector to help addresss staffing and skills shortages. To enable this to be even more effective the development of the Digital staff passport will be essential and will provide a verified record of identity and employment, thus safeguarding patient safety and quality of care. We will look to support opportunities for wider people development rhough the apprenticeship levy transfer.

  We will also strengthen our partnership relationship with our neighbouring University, Edge Hill, exploring improved ways of working and creating opportunities that put us in the best position to deliver services and ensure our existing staff are retained, as well as attracting additional staff in the future.

- **Workforce planning - Skill mix / blended workforce**

  We need to better understand how we can factor into our workforce modelling how digital advancements and technology will impact on our future workforce and how we skill staff to fulfil different or enhanced roles. We will seek to increase the number of (and introduce in some cases) new roles, such as Advanced Clinical Practitioners and Physican Associates, into the workforce to improve resilience and sustainability of services.

- **Effective change management and performance development**

  We must learn to thrive on, and embrace the opportunities, a constantly changing and chaotic environment can bring. Our internal HR and Organisational Development expertise will enable our leaders to adopt best-in-class practices to change management and performance development, including a lessons learned mindset to prevent the same mistakes being repeated to secure our continuous development as a Trust.

  Our staff and managers will be supported to have meaningful, great quality performance and development conversations with their line manager, at least once a year, which enables performance by giving clear direction on the focus of roles, support ongoing development and encouraging aspiration through open, timely and honest feedback on performance.

Operational oversight group

- **Workforce Improvement Group**

  This group, supported by the Trust's Programme Management Office, will monitor the progress and drive delivery of workforce improvement initiatives and transformational change programmes across the Trust.

4. GROWING FOR THE FUTURE

Our aim

To expand and develop our workforce, maximise participation and boost retention of our talented staff.

Key programmes of work

- **Nursing workforce**

  We will continue to evolve our nurse recruitment plan through our engagement with external partners, including local schools, colleges and Higher Education Institutions, Health Education England (HEE), other local Trusts and NHS Professionals, in order to improve workforce supply and strengthen the pipeline to newly qualified nursing posts. We will do this by enhancing student placements and experience; continuing to bid for HEE funding and work with other local trusts on pan-Cheshire and Merseyside initiatives; continuing to offer new routes into nursing and developing the nursing career pathways in line with the current and future apprenticeship offer and continuing professional development.

- **Medical Workforce**

We will ensure there is a well developed recruitment plan in place for the medical workforce, focussed on building strong partnerships with external partners to help address the significant challenges with the supply change. Effective Job Planning, establishment control and alignment of these activities to service planning will support an establishment review of the medical workforce with clarity on medical workforce requirements for the next two years.

- **Specialty Doctor and Associate Specialist (SAS) Development**

  We recognise the significant contribution that this staff group makes to ensuring that we deliver high quality patient care and are committed to ensuring the SAS Charter is embedded within the Trust, and that we facilitate access to ongoing personal and professional development within a nurturing and supportive work environment.

- **Allied Health Professional workforce**

  We will positively promote Allied Health Professionals (AHPs) as a career of choice and support continued development of AHPs, particularly in terms of leadership and improvement. We will work closely with universities to further develop placement capacity and opportunities for apprenticeship developments.

- **International Recruitment**

  There is a current pipeline of international nurse recruits and we will continue to run our international recruitment campaigns and extend to the medical workforce. We will seek all opportunities available for funding to support international recruitment and ensure that there is both pastoral care and on-going support for these staff.

- **Collaborative bank**

  The Doctors in Training collaborative bank has been established and we will build on our experiences to develop collaborative banks for other specialties and disciplines, which will enable greater flexibility for staff, allow experiences in working across organisations, whilst also reducing our dependency on agency staffing. Our next collaborative banks will be focused on Allied Health Professionals and nursing teams.

- **Apprenticeships**

  We will use apprenticeships to boost the opportunities for local people to access employment and careers at this Trust through alternative routes into the healthcare profession. In addition, we will commit to recruiting Bands 1-4 on to apprenticeship opportunities where a suitable standard exists and work collaboratively with the wider regional C&M system and our local universities to grow apprenticeship provision and develop the talent pipeline.

Operational oversight groups

- **Medical Workforce Task Group and Nursing Recruitment Group**

These groups, supported by the Trust's Programme Management Office, will monitor progress against projected workforce trajectories and drive delivery of recruitment initiatives across the Trust. Monthly assurance updates will be provided to the Workforce Committee.

OUR PEOPLE PLAN - OVERVIEW

Key Areas of Focus	Key deliverables 2021/22	Key deliverables 2022/23
Looking after our people • Staff health and wellbeing • Staff engagement and communication • People management practices	Enhanced wellbeing support to support recovery and reset Revise and align staff engagement strategy Re-establish Valuing Our People (Inclusion) Group Deliver on our Staff Engagement Action Plan Align Trust values to staff recognition strategy Implement Schwartz Rounds and continue with 'Back to Floor' Develop an annual HR Policy Development framework and embed Just and Learning principles Develop bitesize sessions for managers for induction and appraisal	Develop Health and Wellbeing strategy to aid new ways of working Increased staff engagement evidenced by staff survey Annual report from Valuing Our People (Inclusion) Group Deliver on our Staff Survey Action Plan Review staff recognition strategy Review Listening Plan Deliver on the HR Policy Development framework Deliver on programme of bitesize sessions to managers
Belonging to the NHS • Promoting inclusion • Improving our leadership culture	Launch the first Trust Diversity calendar of events Incorporate Anti-Racism / Active Bystander training Established Staff Network Health and Wellbeing Hub Revise and align leadership development strategy and develop succession planning framework Introduce reverse mentoring	Annual programme of events to promote and raise cultural awareness Expansion of staff inclusion networks Coaching culture embedded Values based recruitment practices
New ways of working • Agile and digital working • Workforce planning • Change management	Develop Retention strategy and increase opportunities for flexible working Develop HR systems roadmap Develop Trust Clinical Workforce Plan Deliver PDR Improvement Plan	Improved staff retention Delivering a range of online learning opportunities Increased engagement with self-service portal Increased fill of hard to recruit to posts through formalised strategic partnerships Values based approach to change management
Growing for the future • Workforce recruitment and development	Revise and align Recruitment Strategy, and deliver on nurse recruitment (150 IR nurses) Increased placements offered to medical, nursing and AHP students with Edge Hill and UCLAN Extend collaborative bank to Allied Health Professionals	Strengthened pipeline into careers at the Trust Demonstrate commitment to SAS Charter Increased number of Apprenticeships amongst band 1 – 4 roles

MEASURING OUR IMPACT

Recognising diversity is an impact of an inclusive culture, we have identified key workforce indicators to monitor our progress we are making against Our People Plan. These will be reported on a quarterly basis to the Trust's Workforce Committee.

Review metrics following the C&M People Board meeting on 19th Jan to agree metrics to be used to help monitor performance against People Plan.

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB0013/21**	**FOI Exempt**	**No**
Report Title	**EQUALITY DIVERSITY & INCLUSION ANNUAL**		
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Robert Davies, Equality Lead		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The Trust Equality Diversity & Inclusion Report 2019-20 provides a summary of the equality work undertaken by the Trust

Executive Summary

The report highlights how the Trust has been compliant with the Equality Act 2010 Public Sector Duties. The report also highlights how it has met the equality objectives of the quality contracts and a number of NHS England equality requirements i.e. Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES).

A set of Trust Equality Objectives are a legal requirement and a set of equality objective have to be set by the Trust.

Work is underway in partnership with staff and partners i.e. Sefton Clinical Commissioning Group (CCG) Navajo and Healthwatch to ensure that the Trust embeds equality, diversity and inclusion within the Trust and the services it provides to staff patients and carers. The equality objectives set will ensure the Trust develops specific areas of equality and diversity that benefits Trust staff, patients, carers and the public.

Executive Leads have to ensure that they are aware of the Trusts legal and contractual equality obligations. In addition to the various equality reports that must be complied equality updates must be provided to the various Trust committees / groups and externally to NHS England and the Clinical Commissioning Groups (CCG's) as part of the quality contract.

To ensure the Trust is compliant moving forward an equality action plan will be complied and regular updates will be provided to Trust board and the various Trust committees and groups.

Recommendation

The Board is asked to **receive** the report, all workforce information / reports in the report have been to Workforce committee, i.e. WRES WDES reports etc.

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:**
Robert Davies, Equality Lead	Jane Royds, Director of HR and OD

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NHS Trust

EQUALITY, DIVERSITY & INCLUSION ANNUAL REPORT 2019-2020

CONTENTS:

1. FOREWORD

Welcome to the Southport and Ormskirk NHS Trust Equality Diversity & Inclusion Report for 2019/2020. This document includes information about our patient's workforce and our local population and outlines the Trust's commitment to promoting equality in all its functions and to valuing the diversity of staff patients and the local communities.

The provision of high quality patient care is our key driver and the principles of equality, diversity and human rights are intrinsic to the Trust's core business. We are committed to delivering high quality services that are accessible, responsive and appropriate to meet the needs of all our patients. In this respect, patient pathways have been designed to reduce variations in care and improve outcomes, whilst recognising the needs of individual patients.

We aim to be an employer of choice and ensure that all our staff have equality of access to jobs, to promotion and to training opportunities.

The Trust is committed to creating an environment where everyone is treated with dignity, fairness and respect and to developing a culture of support and inclusion for all our employees and for those patients who access our services.

2. ABOUT US

2.1 Our Hospitals

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

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

2.2 Our vision and values

The Trust aims to establish and embed exemplary healthcare. Our values are expressed through "Scope", developed from what staff told us was important to them about the Trust.

They are:
Supportive
Caring
Open and honest
Professional
Efficient

2.3 Objectives of the Trust Strategy

The Trust's corporate strategy contains five objectives or "strategic domains":

- Work with our partner organisations to provide lifelong, integrated care across the local health economy
- Ensure excellence in treatment and care
- Deliver performance, within resources, comparable with the best the NHS can offer
- Empower and develop staff to achieve their objectives
- Maintain organisational sustainability

3. OUR POPULATION

Southport and Ormskirk Hospital NHS Trust provides healthcare to a population of 258,000 people across Southport, Formby and West Lancashire.

After a review of the 2011 census for the local demographics of Sefton and West Lancashire the following information is available that covers ethnicity and commonly used languages:

Sefton: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in Sefton
White		97.40%
Mixed		1.1%
Asian		0.5%
Black		0.3%
Other		0.7%
Totals		**100%**

Source: ONS, 2011 Census: Note: BME includes all other ethnicities besides White. Within Sefton, 97.4% of the population has a White ethnic background and 2.6% of the Sefton population has a Black, Minority Ethnic background (BME).

Sefton's most commonly used languages:
98.0% of people living in Sefton speak English. The other top languages spoken are 0.6% Polish, 0.1% Portuguese, 0.1% All other Chinese, 0.1% Latvian, 0.1% Spanish, 0.1% Lithuanian, 0.1% Arabic, 0.1% Bengali, 0.1% Turkish.

West Lancashire: Ethnicity Population Summary: Census 2011

Ethnicity		% Percentage of the Population in West Lancashire
White		98.10%
Mixed		0.7%
Asian		0.9%
Black		0.1%
Other		0.2%
Totals		**100%**

Source: ONS, 2011 Census: Note: BME includes all other ethnicities besides White. Within West Lancashire, 98.1% of the population has a White ethnic background and 1.9% of the West Lancashire population has a Black, Minority Ethnic background (BME).

West Lancashire's most commonly used languages: 98.0% of people living in West Lancashire speak English. The other top languages spoken are 0.5% Polish, 0.3% Latvian, 0.3% Portuguese, 0.1% Hungarian, 0.1% Slovak, and 0.1% Russian.

4. THE LEGAL CONTEXT

4.1 The Equality Act 2010

The Equality Act 2010 ("the Act") provides the legislative framework to protect the rights of individuals and advance equality of opportunity for all. The Act harmonises and simplifies previous equality legislation with the aim of delivering an accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The Act consolidated 116 separate pieces of equality legislation, principally:

Sex Discrimination Act 1975
Race Relations Act 1976
Disability Discrimination Act 1995

The Act introduced the new terminology of "protected characteristics" to which it then applies, in a consistent way, the traditional elements of direct and indirect discrimination, victimisation and harassment.

The protected characteristics are as follows:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race (includes ethnic or national origins, colour or nationality)
- religion or belief (Including lack of belief)
- sex
- sexual orientation

4.2 Public Sector Equality Duty

The Equality Duty is a duty on public bodies and others carrying out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

The Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective. The

Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services.

The Equality Duty has three main aims. It requires the Trust, in the exercise of all its functions, to have "due regard" to the need to:

- eliminate discrimination, harassment, victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- foster good relations between people who share a relevant characteristic and those who do not share it (in respect of the protected characteristic of marriage and civil partnership, only the duty to eliminate discrimination applies)

Having "due regard" means that the Trust must always consciously think about the three aims of the Equality Duty as part of process of day to day decision-making. This means that consideration of equality issues influences the Trust's decision-making process in how we act as employers; how we develop, evaluate and review policy; how we design, deliver and evaluate services and how we commission and procure from others.

4.3 Equality Impact Assessment (Analysis)

Equality Impact Assessment/Analysis (EIA) is a requirement for all Policies and is part of the Cost Improvement Programmes (CIPs) process which contains both a quality impact assessment and an equality impact assessment. The responsible manager must complete both sections. These steps will help the Trust to ensure that it pays due regard to its obligations under the Public Sector Equality Duty of the Equality Act 2010.

The Trust in 2020-2021aims to develop in partnership the Equality Impact Assessment Template which will increase the level of guidance in the template and will increase staffs understanding of completing the EIA.

Further information about the Equality Act 2010 can be found at the Equality and Human Rights Commission. http://www.equalityhumanrights.com/

4.4 Sector and Workforce Standards

4.4.1 The Workforce Race Equality Standard (WRES)

The NHS Equality and Diversity Council agreed in July 2014 that action across the NHS needs to be taken to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Following a period of consultation, the NHS Equality and Diversity Council agreed two measures that complement each other whilst being distinct to improve equality across the NHS and these would be mandatory requirements embedded within the NHS Contract from April 2015.

There are nine WRES metrics. Four of the metrics are specifically on workforce data and four of the metrics are based on data derived from the national NHS Staff Survey indicators. The latter will highlight any differences between the experience and treatment of White staff and BME staff in the NHS, with a view to closing the gaps highlighted by those metrics. The final metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

The CQC will take this into account within the 'Well Led' domain.

Appendix 1 provides the highlights from the 2018-19 and 2019-20 reports.

4.4.2 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts and Foundation Trusts from April 2019 in light of research showing that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff.

The WDES is a data-based standard that uses a series of measures (metrics) to improve the experiences of disabled staff in the NHS. The ten Metrics have been informed by research by Middlesex and Bedford Universities, conducted on behalf of NHS England, and by Disability Rights UK on behalf of NHS Employers.

The WDES comprises ten metrics. All of the metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, HR data) with the exception of one; Metric 9b asks for narrative evidence of actions taken, to be written into the WDES annual report

The metrics have been developed to capture information relating to the experience of disabled staff in the NHS.

Appendix 2 provides the highlights from the 2019-20 report.

4.4.3 NHS Equality Delivery System 2 (EDS2)

The EDS2 is a public commitment of how NHS organisations plan to meet the needs and wishes of local people and staff, and meet the duties placed on them by the Equality Act 2010. It also sets out how, they recognise the differences between people, and how they aim to make sure that any gaps and inequalities are identified and addressed.

The EDS2 is split into four measurable areas:

1. Better Health Outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Against these four areas there are a set of 18 outcomes. These range from service quality to how staff, are managed in the Trust.

The Trust's assessment is undertaken with key Partners involved in the EDS2 Merseyside Collaborative Group (of which the Trust is an active member). The Group consists of NHS Merseyside organisations who aim to work together on implementing the EDS2 toolkit to develop robust and effective equality objectives across the area jointly and collectively on a number of key priority areas that advance equality of opportunity.

Appendix 3 provides the outcomes of the assessments undertaken in 2017-18 and 2018-19.

The Trust will aim to update on the 2019 assessment in 2020-21.

5. GENDER PAY GAP

The Trust is passionate about creating a fulfilling, diverse and inclusive place to work, with equality and fairness at the heart of our values, policies and everyday practices. That is why we are committed to be an employer of choice and work hard to ensure that our staff have equality of access to jobs, promotion and training and why we highlight to all our staff strategies to overcome Unconscious Bias in all manner of decisions. This and other supportive policies are making the Trust a more inclusive place to work.

As from 30 March 2018, we must publish on our website and on a government website, the following:

- mean gender pay gap
- median gender pay gap
- mean bonus gender pay gap
- median bonus gender pay gap
- proportion of males and females receiving a bonus payment
- proportion of males and females in each pay quartile

The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website.

6. OTHER TRUST EQUALITY INFORMATION

6.1 NAVAJO Chartermark (LGBT+)

The NAVAJO Chartermark was first achieved in March 2015 the Trust was reassessed at the beginning of 2018 and was awarded the NAVAJO charter mark for another year. The NAVAJO Merseyside & Cheshire LGBT+ Charter Mark is an equality mark sponsored by In-Trust Merseyside & Sefton Embrace and supported by the LGBT+ Community networks across Merseyside– a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, transgender and other (LGBT+) people in Merseyside.

6.2 Disability Confident Employers Scheme

The 'Disability Confident' scheme is an initiative which shows employers how to commit to recruiting, retaining and developing disabled people. Through Disability Confident, the Government aims to work with employers in the UK to: challenge attitudes towards disability; increase understanding of disability. The Trust signed up to the Scheme in 2017.

6.3 Partnership Working

The Trust have been actively involved with the N/W, Cheshire & Merseyside and Merseyside EQUAITY Leads forums that consist of Equality Leads form the NHS local councils and 3rd sector organizations.

7. WORKFORCE EQUALITY GOVERNANCE

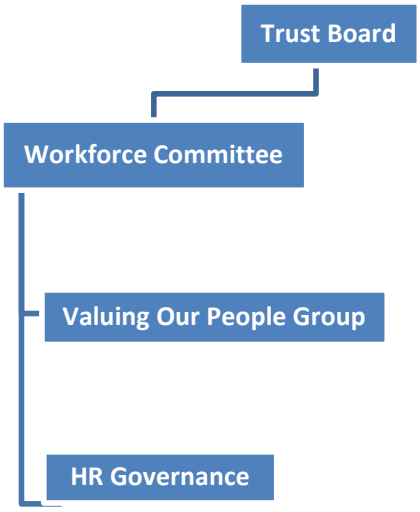
The Equality Act 2010 and the Human Rights Act 1998 provide the legal framework within which the Trust operates its equality governance. Additionally, the Health & Social Care Act 2008, NHS England, the Operating Framework and the NHS Constitution all highlight the need to reduce discrimination in services, improve accessibility and reduce health inequalities for all.

The refreshed Equality Delivery System (EDS2) is the framework by which the Trust can demonstrate how it is performing on issues of equality and health inequality to its patients, staff, communities and commissioners.

At Board level the lead accountability sits with the Director of HR and there is a Non-Executive Director who also acts as an Equality Champion.

The Trust's Valuing People Group, reports through the Workforce Committee and ensures that the Trust complies with externally set standards and establishes, monitors and reviews content and methods of assurance to the Workforce Committee and Patient Experience Groups in relation to all areas of Equality and Diversity.

Governance Structure: Fig1.



8. CARING FOR OUR PATIENTS & CARERS

8.1 Learning Disability

The Trust has a learning disability liaison service which supports care of a patient with a learning disability in a number of ways. The service can be contacted by patients, carers, and community teams regarding any reasonable adjustments required to support access to health services within the Trust i.e. quiet waiting areas in out-patients, specific appointment times, and facilities for carers/ family to stay with patient. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.

Patients who have moderate to severe learning disability can be assessed to have their own funded carer to stay with them throughout admission. This supports familiarity in a strange environment, support with nutritional needs and compliance with treatment which contributes to a positive patient experience and outcome for the patient. The use of Medway alerts allows us to identify patients who have a learning disability and benefits the patient by allowing the communication of any necessary reasonable adjustments, the use of the LD health/hospital passport also supports the sharing of information of the needs of the patient. The service also has a strong relationship with both West Lancashire and Sefton Community LD teams, which enhances care and communication for both planned and unplanned admissions of a patient with a learning disability.

8.2 Accessing Trust Services

The Trust are legally obligated under the Public Sector Equality Duty 2010 to ensure that our services are fully accessible for all people who access Trust services and the provision of a high quality communication service is an essential element that demonstrates compliance with the act.

The Trust aim to actively promote information on the Accessible Information Standard which was implemented on 31 July 2016; the Accessible Information Standard will begin to address any disparity in the care received by disabled people. It will ensure that information is provided to all people who access Trust services in a way they can understand.

Southport and Ormskirk Hospital NHS Trust aim to provide a full range of interpreting and translation services to ensure that the services provided by the Trust are equally and easily accessible to the diverse communities it serves.

The Trust offers the following interpretation and translation services and will provide other services as requested:

- Foreign language translation of Trust documents
- Braille translation of Trust documents
- Face-to-face and telephone interpretation

- British Sign Language interpreting
- Easy-read or large font translation of Trust documents
- Moon Literacy

The Trust has an Interpretation and Translation Service Policy CORP 30 (Appendix A) that provides general guidance for staff on the process and organisations they should use for interpretation & translation.

The Trust has been an active member of the Translation & Interpretation collaborative group that has consisted of all Merseyside NHS Trusts and CCG's and the group have complied a best practice guidance for translation and interpretation.

Monitoring and analysing quarterly translation / interpretation use across the Trust
In order for the Trust to understand who is using our services and to obtain an understanding of the various languages used by carers and patients who access Trust services, quarterly translation and interpretation usage is compiled by the Trust. The information allows the Trust to analyse what languages are most frequently used. We are then able to cross reference the information against the local demographics of the various localities.

8.3 Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for decision-making in relation to people who lack capacity to make decisions for themselves.

The MCA applies to everyone involved in the treatment, care, or support of someone who lacks capacity (including carers and family carers). The Trust staff providing care and treatment to these individuals have a legal obligation to comply with the MCA and associated Mental Capacity Act 2005 Code of Practice. The Trust has a policy which outlines the working practice to embed the requirements of the Act into usual custom, practice and commissioned contracts.

The Mental Health Act 2007 has amended the MCA to introduce a system known as the "Deprivation of Liberty Safeguards" (DoLS). The safeguards came into force on 1st April 2009. The manager must look at all the circumstances of the individual's case and take into account all relevant information, in deciding whether an individual is being deprived of their liberty as a result of their admission to hospital for care and treatment.

The Trust has a named clinical lead for MCA & DOLS.

8.4 Patients with Mental Health Needs

The Trust recognises the evidence that one third of all inpatients are likely to have some sort of mental illness. This means that managing patients with mental health needs is a mainstream part of Trust activity.

Within the Accident and Emergency department there is a designated room for mental health patients under 136 mental health section. The clinical team in the department work closely with Mersey Care NHS Trust to ensure timely assessments and plans for care are implemented. The frail elderly unit have an in reach service from a mental health practitioner to support/advise on the care of patients on the ward .The wards work closely with the mental health liaison nurses from Mersey Care completing timely referrals for mental health assessments. The mental health liaison nurses are integral part of the MDT when best interest meetings are held. Patients are assessed as individual and care is tailored to their needs, additional support with close or continuous supervision is available. Side room facilities are available, with open visiting for relatives / families to support the patient as required.

8.5 Carers Support

The Trust has signed up to John's Campaign to welcome carers whenever they are needed. The campaign recognises the rights of carers to stay with people with dementia at all times. This may be

during the day or night. The Trust has purchased a number of beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission. There are also a number of areas in the Trust which have facilities for carers to utilise to have some quiet space away from the patient bedside. There is a relative's room on critical care, Ward 15a has developed a room for carers to rest and make refreshments, and there is the OASIS room to support family members of patients who are receiving end of life care. For patients on the Regional Spinal Unit, carers who are not local residents are supported in finding local accommodation, for individual cases the Spinal Unit Action Group may also offer an amount of financial support towards this. On the Paediatric unit there is a parent's room where they store food and make refreshments. Comfort bags are available with showering facilities for parents who have children admitted as an emergency.

The Trust Patient Experience Strategy – 'Developing The Experience of Care' is a two year strategy which was launched in July-17. The strategy was co-produced and used themes from complaints, listening events and results from National Surveys to develop and implement eight pledges which aim to improve the patient, family and carer experience. The pledges include implementation of a carer/family charter, improving access to information, improving the collection and profile of patient feedback within the Trust and reviewing discharge processes

Appendix 4 provides a breakdown of patient equality information.

9. NEXT STEPS

It is acknowledged by Southport and Ormskirk NHS Trust that positive actions to support Equality, Diversity and Inclusion underpin the principles of positive staff engagement.

The Trust has developed an action plan to address the areas of shortfall identified. The Action Plan is attached as Appendix 4 and is implemented through the Valuing Our People Group and monitored by the Workforce Committee (sub-committee of the Board of Directors).

The Trust has a separate WRES and WDES Action Plan which is monitored through the same governance structure.

Appendix 1 Workforce Race Equality Standard (WRES)

The information below provides data from the Trust's WRES reports for 2018-19 and 2019-20 and includes a comparison of the Trust's data to the average for combined acute and community hospital.

1. Extracts from the self-populated WRES template provided by NHS England

- ***BME staff increase in clinical and non–clinical bands***
  The 2019-20 WRES report highlights that BME staff in non-clinical roles has seen an increase in bands 2, 4, 7. BME staff in clinical roles has seen an increase in Bands 4, 7, 8a.

- ***Relative likelihood of BME and white staff being appointed from shortlisting across all posts***
  15.22% of BME staff were hired from those shortlisted compared to 24.84% of white applicants hired from shortlisting in 2019-20.

  The 2019-20 WRES data highlights that there has been an increase in BME staff being successful at interview and being hired by the Trust. 2019-20 = 15.22% compared to 3.70% in 2018-19 this is an increase of 11.52%.

- ***Relative likelihood of BME and white staff entering the formal disciplinary process***
  The number of BME staff (1) entering the disciplinary process in 2019-20 is the same as the 2018 -19 WRES figures.

2. Staff Data

2.1 Workforce profile

Table 1

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff *Notes:* *Definitions are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.* *Where the % rate does not equate to 100% this is due to information not stated*	**Non – Clinical**				
	2018-19			**2019-20**	
	Band	**BME**	**White**	**BME**	**White**
	Band 1	7.17%	84.75%	.0%	0%
	Band 2	1.29%	93.89%	4.20%	87.61%
	Band 3	4.0%	86.40%	1.84%	88.96%
	Band 4	0.61%	95.09%	1.23%	93.87%
	Band 5	1.96%	90.20%	1.56%	92.19%
	Band 6	1.96%	94.12%	1.85%	88.89%
	Band 7	3.45%	86.21%	4.88%	87.80%
	Band 8a	4.76%	90.48%	3.70%	85.19%
	Band 8b	0.00%	100%	0.00%	92.86%
	Band 8c	0.00%	100%	0.00%	100%
	Band 8d	14.29%	85.71%	0.00%	100%
	Band 9	0.00%	100%	0.00%	0.00%
	2017-18				
	VSM	16.67%	83.33%	16.67%	83.33%
	CQIR	0.00%	100%	0%	0%
	IRPM	0.00%	100%	0%	0%
	WCOO	0.00%	100%	0%	0%

	Clinical			
	2018-19		**2019-20**	
	Band	**BME**	**White**	**BME**	**White**
	Band 2	9.68%	80.24%	6.41%	79.72%
	Band 3	2.97%	91.82%	2.51%	92.05%
	Band 4	0.00%	96.08%	3.70%	91.36%
	Band 5	7.10%	87.33%	6.87%	82.82%
	Band 6	5.32%	90.05%	5.16%	89.67%
	Band 7	1.35%	91.89%	2.65%	88.94%
	Band 8a	8.62%	86.21%	9.84%	88.52%
	Band 8b	0.00%	91.30%	0.00%	92.59%
	Band 8c	0.00%	100%	0.00%	100%
	Band 8d	0.00%	100%	0.00%	50%
	VSM	0.00%	100%	0.00%	100%
	WHO3	0.00%	100%	0.00%	100%
	WHO7	16.67%	66.67%	16.67%	66.67%
	Med & Dental Consultant			
	2018-19		**2019-20**	
	BME 42.06%	**White** 42.99%	**BME** 45.45%	**White** 40.40%
	Med & Dental Consultant Non –Consultant Career Grade			
	2018-19		**2019-20**	
	BME 56.38%	**White** 28.72%	**BME** 55.95%	**White** 28.57%
	Medical & Dental Trainee Grades			
	2018-19		**2019-20**	
	BME 23.91%	**White** 66.30%	**BME** 31.57%	**White** 61.90%
	Board- Ex- Non Exec			

	2018 -19		**2019-20**	
	BME 18.18%	**White** 84.62%	**BME** 14.29%	**White** 78.57%

2.2 Recruitment activity

Table 2 Relative likelihood of white staff being **appointed from shortlisting** compared to BME staff

2018-2019	2019-20	Difference
times more likely 1.61 Auto calculated	times more likely 1.63 Auto calculated	0.02

2019 -20	**Headcount**		**Relative likelihood of appointment from shortlisting**
	Shortlisted	Hired	Hired- %
BME	335	51	15.22%
White	1727	429	24.84%
Unknown	84	10	11.90%

2018 - 19	Headcount		Relative likelihood of white staff appointment from shortlisting
	Shortlisted	Hired	Hired%
BME	432	16	3.70%
White	2515	150	5.96%
Unknown	80	9	11.25%

2.3 Employee Relations activity

Tables 3 Relative likelihood of BME staff entering into **formal disciplinary process** compared to white staff

2018-2019	2019-20	Difference
times more likely 0.45 Auto calculated	times more likely 2.72 Auto calculated	2.27

2019-20	Head Count	Relative likelihood of BME staff entering into formal disciplinary process compared to white staff
BME	1	0.42%
White	4	0.15%
Not Stated	1	0.38%
Total	**6**	

2018-19	Head Count	Relative likelihood of BME staff entering into formal disciplinary process compared to white staff
BME	1	0.41%
White	23	0.90%
Not Stated	1	0.52%
Total	**25**	

2.4 Training and Development activity

Tables 4 Relative likelihood of white staff accessing **non-mandatory training & CPD** compared to BME staff is

2018-2019	2019-20	Difference
White staff 0.91 times more likely Auto calculated	White staff 0.99 times more likely Auto calculated	0.08

2019-20	Head Count	Enrolment Head Count	Ratio
BME	240	240	100%
White	2612	2589	99.12%
Not Stated / Not Given	263	263	100%

2018-19	Head Count	Enrolment Head Count	Ratio
BME	245	243	99.19%
White	2551	2315	90.75%
Not Stated / Not Given	191	176	92.15%

3. NHS Staff Survey

The 2019 NHS Staff Survey was completed by **1,348** staff this is a response rate of **47.1%** which is average for combined acute and community trusts in England **(47.5%)** and compares with a response rate in the Trust in 2018 of **(40%)**.

3.1 NHS staff survey responses specific to WRES

Q1/ The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
In the last 12 months Trust figures for white staff has seen a decrease of -1.4% and a +2% increase for BME staff.

The Trust figures compared to the average combined acute and community Trusts is -1.2% lower for white staff and +1.5% higher for BME staff.

Q2/ Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
Experiences of Trust staff experiencing harassment; bullying or abuse from staff in last 12 months has seen a -2.1% decrease for white staff and a decrease of -0.9% for BME staff.

The Trust figures compared to the average combined acute and community Trusts is 2.2 lower for white staff and -3.2% lower for BME staff.

Q3/ Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion.
Experiences of white staff have seen an increase of +2.8% and a decrease of -2.1% for BME staff.

The Trust figures compared to the average combined acute and community Trusts is -3.4% lower for white staff and +3.9% higher for BME staff.

Q4/ In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader or other colleagues?
Experience of white staff has seen a 0.6% decrease from 2018 and there has been an decrease of 1.8% from 2018 for BME staff

The Trust figures compared to the average combined acute and community Trusts is 0.4% higher for white staff and 2% lower for BME staff.

3.2 Staff Survey Indicators

For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff.

Key findings KF25, KF26, and KF21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question Q17, the percentage featured is that of "Yes" responses to the question.
Key finding and question numbers are the same in 2019 as 2018.
*N.B Figures in **bold** highlight BME figures.*

- **Indicator 5**

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:

Experiences of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has seen the figures for white staff decrease by 1.4% and a **2% increase for BME staff**

Data for previous year 2018	Data for reporting year 2019	2019 Average (median) for
White staff 28.4 % BME staff : 29.4%	White staff 27.0 % BME staff : 31.4%	Combined Acute and Community Trusts White staff– 28.2% BME staff- 29.9% **SOHT– 1.5% above average for BME staff**

- **Indicator 6**

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Experiences of experiencing harassment, bullying or abuse from staff in last 12 months has seen a 2.1% decrease for white staff and a **decrease of 0.9% for BME staff**.

Data for previous year 2018	Data for reporting year 2019	2019 Average (median) for
White staff 25.7 % BME staff : 26.5%	White staff 23.6 % BME staff : 25.6%	Combined Acute and Community Trusts White staff– 25.8% BME staff- 28.8% **SOHT– 3.2% below average for BME staff**

- **Indicator 7**

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

Experience of white staff has seen an increase of 2.8% increase for white staff and **an increase decrease of 2.1% for BME staff.**

Data for previous year 2018	Data for reporting year 2019	2019 Average (median) for
White staff 80.5 % BME staff : 80.4%	White staff 83.3 % BME staff : 78.3%	Combined Acute and Community White staff– 86.7% BME staff- 74.4% **SOHT+ 3.9% above average for BME staff**

- **Indicator 8**

In the last 12 months have you personally experienced discrimination at work from any of the following manager / team leader or other colleague

Experience of white staff has seen a 0.6% decrease from 2018 and there has been a **decrease of 1.8% from 2018 for BME staff**

Data for previous year 2018	Data for reporting year 2019	2019 Average (median) for
White staff 7.0 % BME staff : 13.6%	White staff 6.4 % BME staff : 11.8%	Combined Acute and Community Trusts White staff– 6.% BME staff- 13.8% **SOHT– 2.% below average for BME staff**

- **Indicator 9**

Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

  - By voting membership of the Board
  - By executive membership of the Board

The information below provides information on the headcount and percentage difference between the organisations board membership and its overall workforce for BME and White Staff.

By Executive and Non-Executive Board membership =
BME: 14.29% White:78.57% Not Stated: 7.14%

2019-20

Headcount		Headcount %	Board Headcount	Board Headcount %
BME	246	7.70%	2	14.29%
White	2791	83.88%	11	78.57%
Not Stated	310	8.44%	1	7.14%

2018-19

	Headcount	Headcount %	Board Head count	Board Headcount %
BME	258	8.18%	2	14.29%
White	2679	84.97%	11	78.57%
Null	23	0.73%	0	0.00
Not Stated	193	6.12%	1	7.14%

Appendix 2 Workforce Disability Equality Standard (WDES)

1. Key findings from the WDES report 2019-20

- Recording a disability

  Trust figures on ESR highlight 2.63% staff out of 3115 staff have a disability.

  NHS Staff Survey highlights 22.5% of staff out of the 1,348 who completed the NHS Staff Survey highlighted they have a disability.

- Disabled staff being appointed from shortlisting is 3.81% for disabled compared to 12% for non-disabled staff.

- ESR data highlights the relative likelihood of staff entering the formal capability process for disabled or non-disabled staff is the same at 0%

- Disabled staff experiencing harassment; bullying or abuse from patients, relatives or the public is 6.3% higher than for non-disabled staff.

- Disabled staff experiencing harassment, bullying or abuse from managers is 10.8% higher than non-disabled staff.

- Disabled staff experiencing harassment, bullying or abuse from other colleagues is 7.8% higher than non-disabled staff.

- Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion is 76.3% for disabled staff and 84.7% for non-disabled staff,

2. Staff Profile

Table 1

Disability	Headcount	Percentage %
No	2159	69.30% of staff don't consider themselves to have a disability
Not Declared	108	28.05% of staff have not declared preferred not to say or unspecified
Prefer Not To Answer	1	
Unspecified	765	
Yes	82	2.63% of staff have highlighted they have a disability
Grand total	**3115**	

3. Workforce Disability Equality Standard Indicators

Three workforce indicators compare the data for both disabled and non-disabled staff.

Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

For each of workforce indicators, the standard compares the metrics for disabled and non-disabled staff were the figures don't equate to 100% this is due to the information not stated / not given

3.1 Workforce Indicator 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Clusters:
Cluster 1 (Bands 1 - 4)
Cluster 2 (Band 5 - 7)
Cluster 3 (Bands 8a - 8b)
Cluster 4 (Bands 8c - 9 & VSM
Cluster 5 (Medical & Dental Staff, Consultants)
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)

Table 2 Current Year 2019 – 20

Non – Clinical		
Cluster	**Disabled**	**Non-Disabled**
Cluster 1	3.72%	59.64%
Cluster 2	3.77%	66.03%
Cluster 3	2.43%	63.41%
Cluster 4	0%	100%
Clinical		
Cluster	**Disabled**	**Non-Disabled**
Cluster 1	2.16%	72.27%
Cluster 2	2.46%	73.46%
Cluster 3	2.27%	68.18%
Cluster 4	0%	92.30%
Cluster 5:	**Med & Dental Consultant**	
Disabled		**Non-Disabled**
0%		63.63%
Cluster 6:	**Med & Dental Consultant Non –Consultant Career Grade**	
Disabled		**Non-Disabled**
2.23%		66.66%
Cluster 7	**Medical & Dental Trainee Grades**	
Disabled		**Non-Disabled**
0%		100%

3.2 Workforce Indicator 2 - Relative likelihood of non-disabled staff to disabled being appointed from shortlisting across all posts

Table 3	**Head Count**		
WDES Category	Shortlisted	Appointed	Relative likelihood of staff shortlisted /appointed
Disabled	50	6	0.12 3.81%
Non-Disabled	1188	111	0.09 12%
Not declared	229	2	0.01 0.87%
Relative likelihood of relative likelihood of Non-Disabled staff being appointed from shortlisting compared to Disabled staff.			0.78 times more likely

3.3 Workforce Indicator 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

This metric will be based on data from a two-year rolling average of the current year and the previous year.

Table 3 2018-19 and 2019-20

Average over 2 years	Entering formal capability Process	Trust Headcount	Relative likelihood of staff entering the formal capability process
Disabled	0	82	0%
Non-Disabled	0	2160	0%
Not declared Prefer not to answer Unspecified	0 0 0	873	0%
Total	0	3115	0%
Relative likelihood of disabled staff compared to non-disabled staff			0

4. NHS Staff Survey

The 2019 NHS Staff Survey was completed by **1,348** staff this is a response rate of **47.1%** which is average for combined acute and community trusts in England **47.5%** and compares with a response rate in the Trust in 2018 of **40%**

4.1 NHS staff survey responses specific to WDES Indicators ?

- **Indicator 4a** Percentage (%) of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from:

Category	Question	2018	2019	Average from Trusts
Non-disabled	Patients/service users, relatives or public	26.7%	25.9% 0.8% **Reduction**	27.3% **1.4% below average**
	Manager	11.5%	11% 0.5% **Reduction**	11% - **Same**
	Other colleagues	15.9%	16.3% 0.4% **Increase**	18.4% **2.1% below average**
Disabled	Patients/service users, relatives or public	37.3%	32.2% = **5.1% reduction**	33.9% **1.7% below average**
	Manager	24.4%	21.8% **2.6% reduction**	19.7% **2.1% above average**
	Other colleagues	30.8%	24.1% **6.7% reduction**	28.1% **4% below average**

The results form the latest staff survey in 2019 indicate that disabled staff are more likely to have experienced harassment, bullying or abuse from Patients/Service users, relatives or other members of the public and from their managers than non-disabled staff.

- **Indicator 4b** Percentage of disabled staff compared to non – disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Category	2018	2019	Average from Trusts
Non-disabled	46.5%	48% **1.5% increase**	45.6% **2.4% above average**
Disabled	52.8%	48.5% **4.3% reduction**	46.7% **1.8% above average**

The result from the latest staff survey could indicate that staff with or without a disability could have an issue with reporting an experience of harassment, bullying or abuse at work.

- **Indicator 5** Percentage believing that Trust provides equal opportunities for career progression or promotion

Category	2018	2019	Average from Trusts
Non-disabled	80.9%	84.7% **3.8% increase**	85.6% **0.9% below average**
Disabled	78.5%	76.3% **2.2% reduction**	79.1% **2.8% below average**

The results show a reduction in disabled staff believing the Trust provides equal opportunities or career progression or promotion compared to last year, there has been an increase for non –disabled staff.

- **Indicator 6** Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Category	2018	2019	Average from Trusts
Non-disabled	19.7%	17.9% 1.8% decrease	22.4% 4.5% below average
Disabled	31.8%	32.1% 0.3% increase	32.7% 0.6% below average

The results highlight that disabled staff are more likely to feel pressure from their manager to come to work than none disabled staff.

- **Indicator 7** Percentage of Disabled staff compared to non – disabled staff saying that they are satisfied with the extent to which their organisation values their work

Category	2018	2019	Average from Trusts
Non-disabled	37.8%	44.4% 6.6% increase	49.5% 5.1% below average
Disabled	26.9%	31.0% 4.1% increase	37.4% 6.4% below average

The results of the latest survey highlight that disabled staff are LESS likely to feel satisfied to which the Trust values their work.

- **Indicator 8** Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Category	2018	2019	Average from Trusts
Disabled	76.2%	70.5% 5.7% decrease	73.3% 2.8% below average

- **Indicator 9a** The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Category	2018	2019	Average from Trusts
Non-disabled	6.6%	6.9% 03% increase	7.1% 0.2% below average
Disabled	6.2%	6.2% Same	6.6% 0.4% below average
Trust average	6.5%	6.7%	

- **Indicator 9b** Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **(Yes)** or (No)

Staff & Family Friends Test	NHS Staff Survey
Big Brew / Conversation	Setting Up of a Disability Staff Network
So Proud Pulse Check	Disability Confident Employer Scheme
Reasonable Adjustment Disability Passport	

- **Indicator 10** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

Disability	Headcount	Headcount %	Board Headcount	Board Headcount %
No	2160	69.34	14	100.00
Not Declared	108	3.47	0	0.00
Prefer Not To Answer	1	0.03	0	0.00
Unspecified	765	24.56	0	0.00
Yes	82	2.63	0	0.00

Appendix 3 NHS Equality Delivery System 2 (EDS2)

In February 2019, the Trust undertook its EDS2 assessment against the EDS2 goals 1 & 2 and invited key stakeholders to the assessment process Healthwatch Lancashire and representatives from Sefton CCG attended.

The EDS2 Partner's 2019-20 assessment graded theTrust as follows:

1. Equality Delivery System 2: Goal 1 'Better health outcomes for all'

Individual Outcome grades for Goal 1:	2017-18	2018-19
EDS2 Outcome 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Developing**	**Achieving**
EDS2 Outcome 1.2 Individual people's health needs are assessed and met in appropriate and effective ways	**Developing**	**Achieving**
EDS2 Outcome 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Developing**	**Achieving**
EDS2 Outcome 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Developing**	**Achieving**
EDS2 Outcome 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	**Developing**	**Achieving**

2. Equality Delivery System 2: Goal 2 'Improved patient access and experience'

Individual Outcome grades for Goal 2:	2017-18	2018-19
EDS2 Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Developing**	**Achieving**
EDS2 Outcome 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	**Developing**	**Achieving**
EDS2 Outcome 2.3 People report positive experiences of the NHS	**Developing**	**Developing**
EDS2 Outcome 2.4 People's complaints about services are handled respectfully and efficiently	**Developing**	**Achieving**

3. Equality Delivery System 2: Goal 3 'Empowered, engaged and well-supported staff'

Individual Outcome grades for Goal 3:	2017-18	2018-19
EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Developing**	**Achieving**
EDS2 Outcome 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Developing**	**Developing**

EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff	**Developing**	**Developing**
EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	**Developing**	**Developing**
EDS2 Outcome 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Developing**	**Developing**
EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce	**Developing**	**Developing**

4. Equality Delivery System 2: Goal 3 'Inclusive Leadership'

Individual Outcome grades for Goal 4:	**2017-18**	**2018-19**
EDS2 Outcome 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**	**Achieving**
EDS2 Outcome 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Developing**	**Achieving Board Only** **Developing Other committees**
EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Developing**	**Developing**

Appendix 4 Workforce Information

1. Workforce profile

1.1 Overview

As of March 2020 Southport and Ormskirk Hospital NHS Trust employed 3115 people of which:

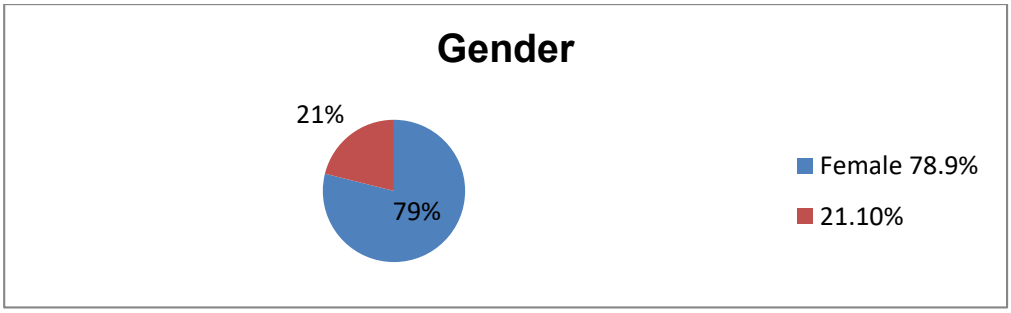
- **Gender**
  78.9% of the workforce are Female and 21.1% are Male
- **Age**
  24.5% of the workforce are aged 35yrs and under, 49.69% of staff are 36yrs to 55yrs of age and 25.81% are aged over 55 years of age
- **Ethnicity**
  The Trust workforce consists of 10.62% from Black Minority and Ethnic groups 80.93% White staff and 8.44% not stated unspecified prefer not to answer.
- **Disability**
  2.63% of the Workforce have disclosed that they consider themselves to have a Disability, 69.30% of staff have told us they don't consider themselves to have a Disability with the remainder 28.05% either not declaring - other.
- **Sexual Orientation**
  81.57% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.12% as Lesbian or Gay, 0.39% Bisexual with the remainder Not disclosed 7% and 9.92% Unspecified.
- **Religion & Belief**
  62.40% Christian, 8.57% Atheists, Islam 1.66%, Hinduism 1.44% with Not Disclosed 21.86% and all other 4.04%
- **Employment Status**
  54.67% Fulltime Staff and 45.33% Part time staff.
- **Length of Service**
  The highest proportion of the workforce have been employed by the Trust between 6-29 years 52.55%, 1 to 5 years 27.80%,15.70% of the workforce have been with the with the Trust for under 1 year and 3.95% of the Trust have been employed by the Trust for 30 years and over

Workforce data below provides a general overview of staff ethnicity, gender, religion and belief, sexual orientation, disability employment status, length of service and recruitment.

Data figures in the various graphs are rounded up to the nearest point, the exact data figures are highlighted to the right of the graph.

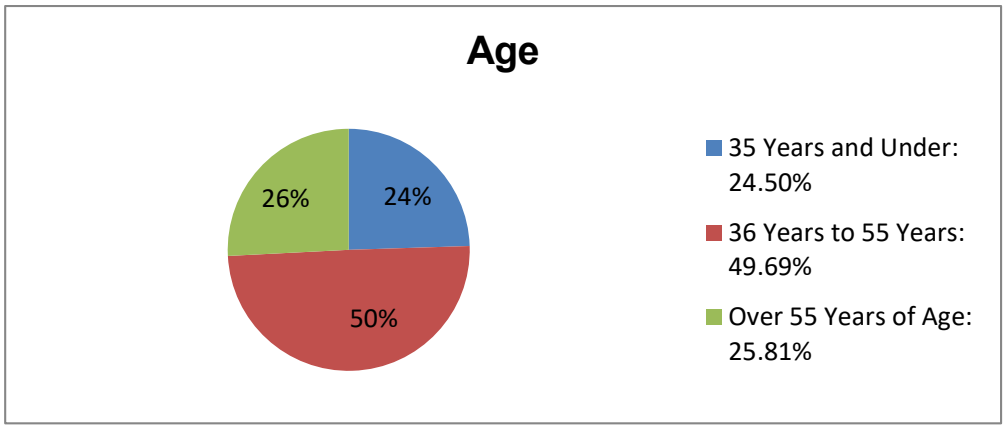
1.2 Gender

78.9% of the workforce is Female and 21.1% are Male



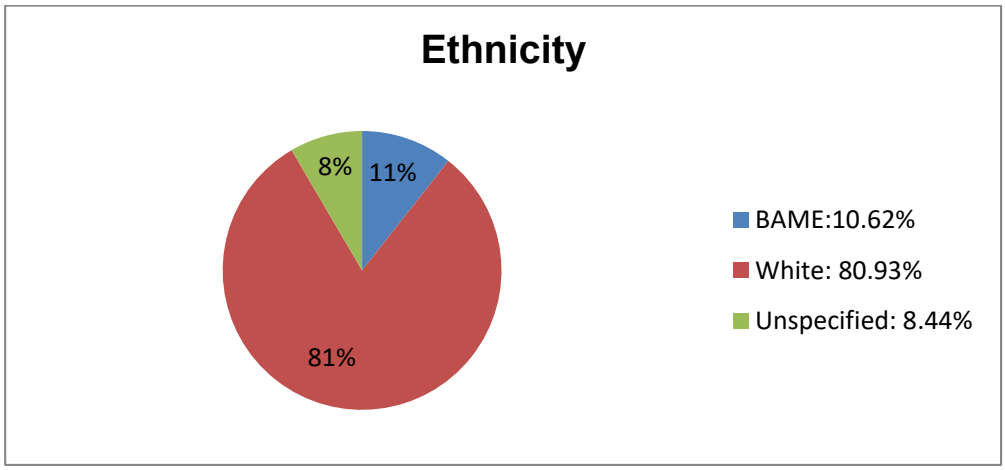
1.3 Age Profile

24.50% of the workforce is aged 35yrs and under, 49.69% of staff are 36yrs to 55yrs of age and 25.81% are aged over 55 years of age.



1.4 Ethnicity

The Trust workforce consists of 10.62% from Black Asian and Minority Ethnic groups 80.93% White staff and 8.44% Not Stated or Unspecified.

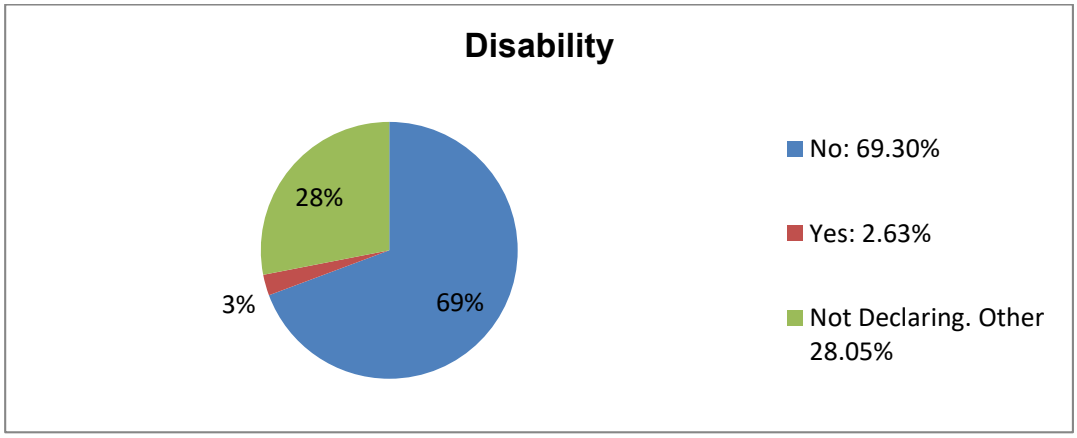


Ethnic Origin	Headcount	Percentage
A - White British	2496	80.93% White staff (2,521)
B - White Irish	25	
C - Any Other White	91	
D - Mixed White/Black Caribbean	6	
E - Mixed White/Black African	6	
F - Mixed White/Asian	5	
G - Mixed Other	7	
H – Indian	79	
J – Pakistani	20	
K – Bangladeshi	1	
L - Other Asian	49	
M - Black Caribbean	1	
N - Black African	18	10.62% from Black Minority and Ethnic groups (331)
P - Black Other	7	

R – Chinese	5	
S - Other Ethnic Group	36	
Unspecified	102	8.44% Not Stated or Unspecified (263)
Z - Not Stated	161	
Grand Total	**3115**	**100%**

1.5 Disability

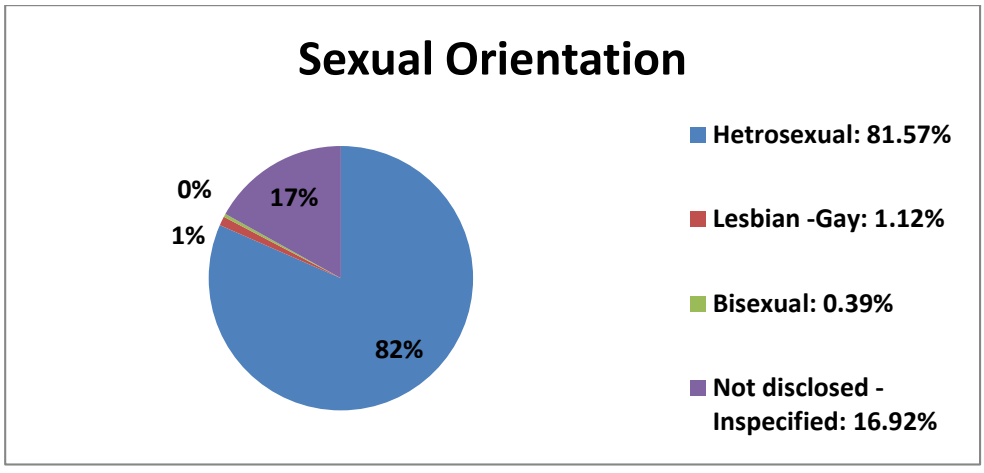
2.63% of the Workforce informed the Trust that they consider themselves to have a disability, 69.30% of staff have told us they don't consider themselves to have a disability with the remainder 28.05% either not declaring – other.



Disability	Headcount	Percentage %
No	2059	69.30% of staff don't consider themselves to have a disability
Not Declared - Other	974	28.05% not disclosed
Yes	82	2.63% of staff consider themselves to have a disability
Grand Total	**3115**	

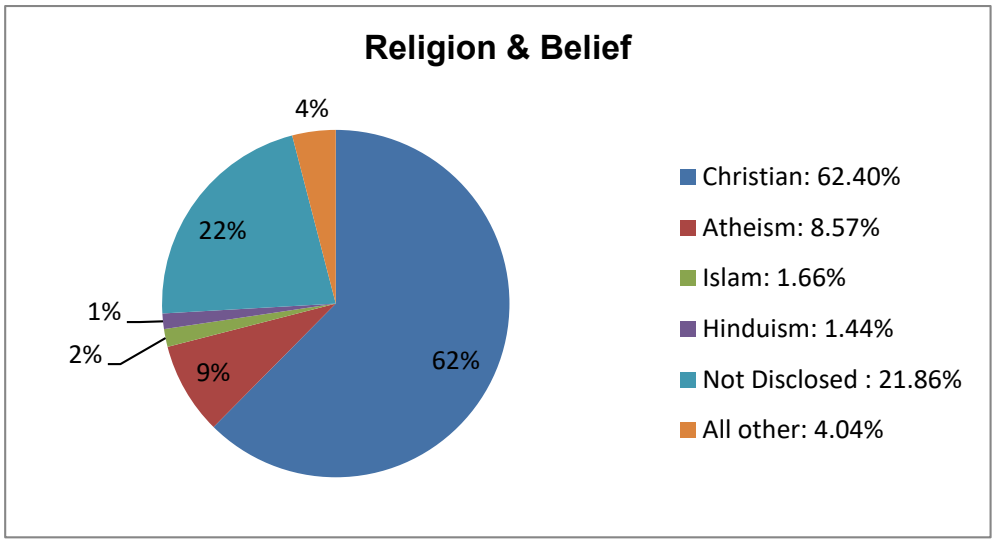
1.6 Sexual Orientation

81.57% of staff have disclosed their sexual orientation as Heterosexual or Straight, 1.12% as Lesbian or Gay, 0.39% Bisexual with the remainder 16.92% Not disclosed - Unspecified.



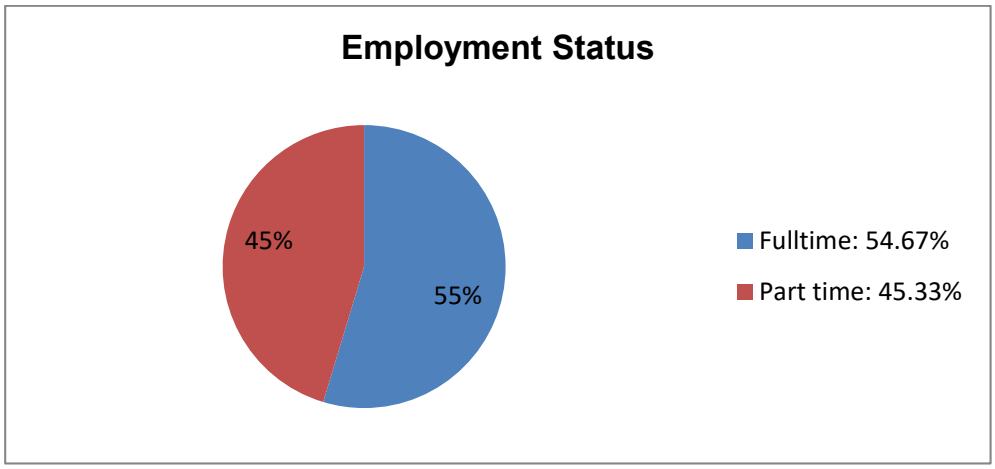
1.7 Religion & Belief

The 4 highest religions & beliefs at the Trust are as follows 62.40% Christian, 8.57% Atheists, Islam 1.66% Hinduism 1.44% with Not Disclosed 21.86% and All Other 4.04%



1.8 Employment Status

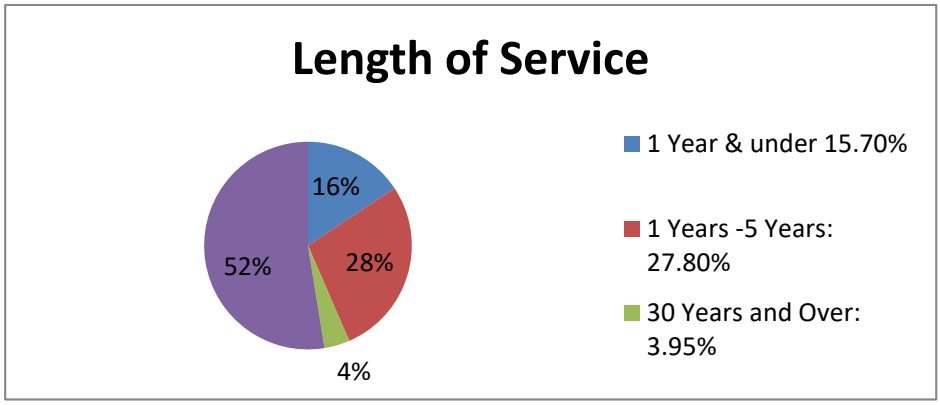
The workforce consist of 54.67% Fulltime Staff and 45.33% Part time Staff



Employee Category	Female%	Male %
Fulltime	37.43%	17.21%
Part Time	41.48%	3.88%
Grand Total Workforce %	**78.91%**	**21.09%**

1.9 Length of service

The highest proportion of the workforce have been employed by the Trust for between 1-5 years 27.80%, 15.70% of the workforce have been with the with the Trust for under 1 year and 3.95% of the Trust have been employed by the Trust for 30 years and above



Length of Service Band	Percentage %
<1 Year	15.70%
1<5 Years	27.80%
5<10 Years	17.405
10<15 Years	12.23%
15<20 Years	13.42%
20<25 Years	5.46%
25<30 Years	4.04%
30+ Years	3.95%
	100%

2. Recruitment activity

2.1 BAME and Staff with a Disability / Long-term Condition being appointed from Shortlisting

Ratio of BME and White Staff being appointed from short listing; *this refers to both internal and external posts.*

Relative likelihood of White staff being appointed from shortlisting compared to BME staff is;

	Head Count		Percentage %
WRES Category	Shortlisted	Appointed	Relative likelihood of staff shortlisted /appointed
BME	335	51	15.22%
White	1727	429	24.84%
Unknown	84	10	11.90%
Relative likelihood of White staff being appointed from shortlisting compared to BME staff is.			1.63 times more likely Auto - calculated

Relative likelihood of non-disabled staff to disabled being appointed from shortlisting across all posts;

	Head Count			
WDES Category	Shortlisted	Appointed	Relative likelihood of staff shortlisted /appointed	
Disabled	50	6	0.12	3.81%
Non-Disabled	1188	111	0.09	12%
Not declared	229	2	0.01	0.87%
Relative likelihood of relative likelihood of Non-Disabled staff being appointed from shortlisting compared to Disabled staff.			0.78 times more likely	

Appendix 5 Patient Information

1. Patient profile data

1.1 Overview

As of March 2020 Southport and Ormskirk Hospital NHS Trust provided services to 407,544 patients (88,166 AED patients, 60,941 Inpatients and 258,437 Outpatients).

- **Gender**
  58.01% of patients are Female 41.97% Male and 00.02% Not Known
- **Age**
  33.30% of the patients are aged 35yrs and under, 16.16% of patients are 36yrs to 55yrs of age and 53.79% are aged 56 years of age and over
- **Ethnicity**
  The ethnicity of patients accessing Trust services are 4.75% from Black Minority and Ethnic groups 90.32% White staff and 4.93% Not Specified.
- **Religion & Belief**
  The 4 highest religions & beliefs for patients accessing Trust services are as follows 39.79% Church of England, 18.31% Roman Catholic, 3.91% Christian, 2.21% Methodist 15% all others 20.78% unknown
- **Marital Status**
  39.69% of patients are Married or in a Civil Partnership, 37.73% Single, 7.97% Widow / Surviving Civil Partnership, 5.46% Divorced/Dissolved Civil Partnership, 8.39% Unknown / Not Disclosed and 0.76% Separated

The patient data below provides a general overview of patient gender, age, ethnicity, religion and belief, marital status. Data figures in the various graphs are rounded up to the nearest point.

1.2 Gender

58.01% of the patients are Female 41.97% are Male and 00.02% Not Known

Graph 1

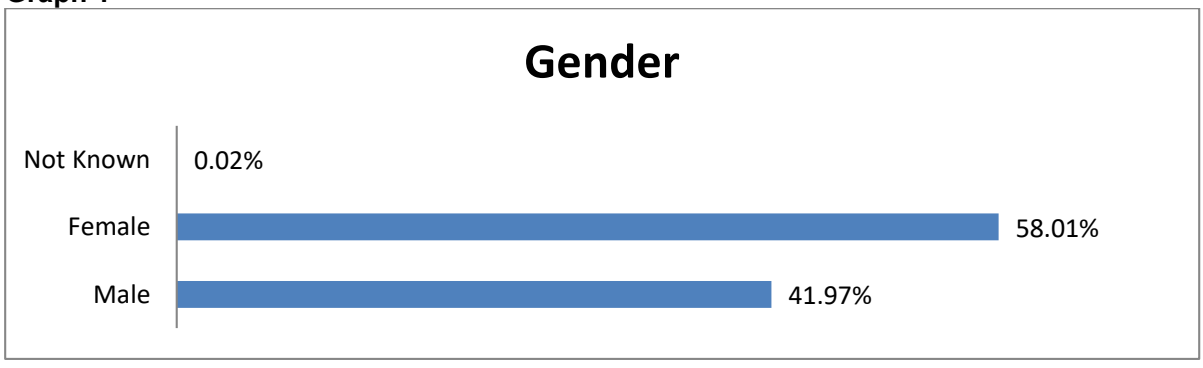


Table 1

Gender	Headcount	Percentage %
Female	236,427	58.01%
Male	171,082	41.97%
Not Known / Specified	35	00.02%
Grand Total	**407,544**	**100%**

1.2 Age

33.30% of Patients are aged 35yrs and under, 16.66% of patients are 36yrs to 55yrs of age and 50.04% are aged 56 years of age and over

Graph 2

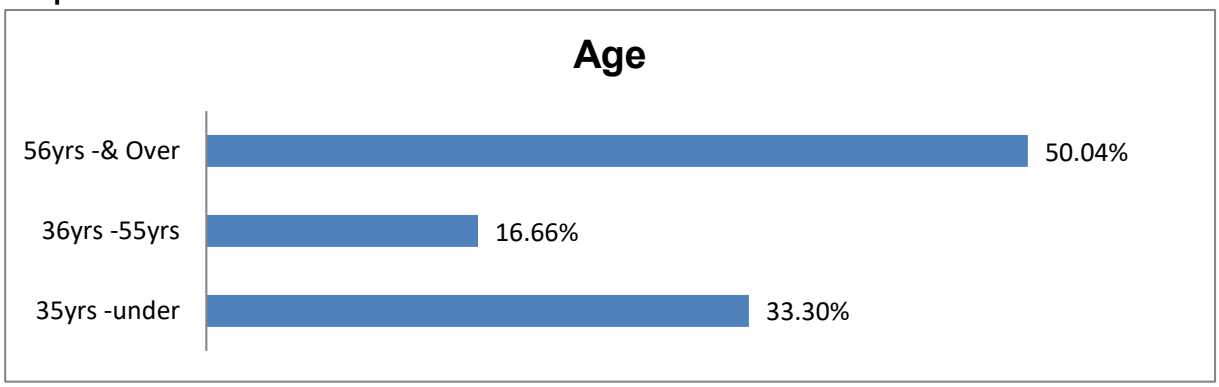


Table 2

Age Band	AED	Headcount Outpatients	Headcount Inpatients	Total Patients
<=18 Years	30711	23836	7785	62568
18-24	5220	13520	2366	21106
25-34	6577	40780	4859	52226
35-44	5690	22697	4015	32402
45-54	7139	23048	5291	35478
55-64	7915	33428	7649	48992
65-74	8417	43145	10358	61920
75 +	76	57983	18625	93045
Total	**88166**	**258437**	**60941**	**407544**

1.3 Ethnicity

The ethnicity of patients accessing Trust services are 4.75% from Black Minority and Ethnic groups 90.32% White staff and 4.93% Not Specified.

Graph 3

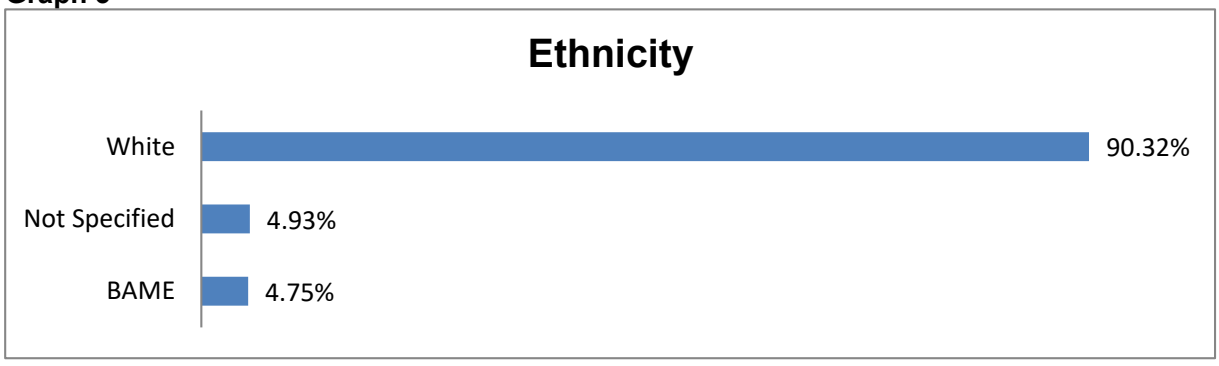


Table 3

Ethnic Group	Headcount	Percentage %
White	368,110	90.32%
Not Specified	20,080	4.93%
BAME	19,354	4.75%
Total	**407,544**	**100%**

1.4 Religion & Belief

The 4 highest religions & beliefs for patients accessing Trust services are as follows 39.79% Church of England, 18.31% Roman Catholic, 3.91% Christian, 2.21% Methodist, 20.78% Unknown and 15% All Others

Graph 4

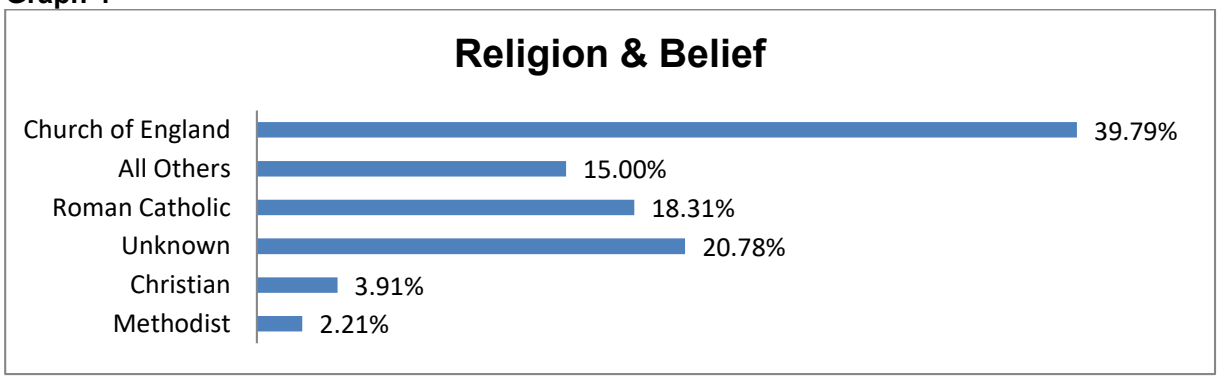


Table 4

Religious Belief	Headcount	Percentage %
Church of England	162,179	39.79%
Roman Catholic	74,609	18.31%
Christian	15,923	3.91%
Methodist	8,996	2.21%
Unknown	84,674	20.78%
Others	61,163	15.00%
Total	**407,544**	**100%**

1.5 Marital Status

39.69% of patients are Married or in a Civil Partnership, 37.73% Single, 7.97% Widow / Surviving Civil Partnership, 5.46% Divorced/Dissolved Civil Partnership, 8.39% Unknown / Not Disclosed and 0.76% Separated.

Graph 5

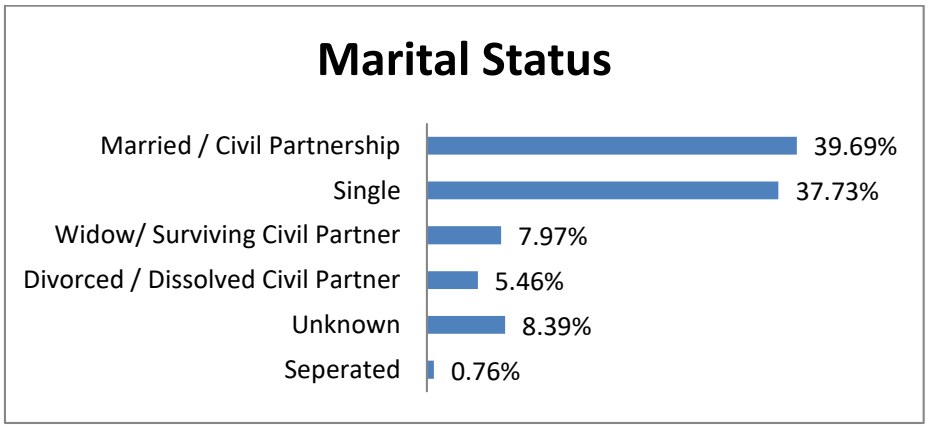


Table 5

Marital Status	Headcount	Percentage %
Divorced/Dissolved Civil Partnership	22,238	5.46%
Married/Civil Partnership	161,776	39.69%

Not disclosed / Unknown	34,222	8.39%
Separated	3,131	0.76%
Single	153,744	37.73%
Widow / Surviving Civil Partnership	32,443	7.97%
Grand Total	**407,544**	**100%**

NHS
Southport and Ormskirk Hospital
NHS Trust

Equality Objective Plan 2018 - 2021

Equality Objective Themes:

1. Improving our Intelligence
2. Developing our Staff
3. Working within our Communities

Southport & Ormskirk Hospital NHS Trust Equality Objectives 2018-2021

Southport & Ormskirk Hospital NHS Trust Values: SCOPE
Supportive Caring Open & Honest Professional Efficient

Improving our Intelligence	Developing our Staff	Working within our Communities
• Develop a Trust-wide approach to collecting equality information • Review current patients accessing Trust services data/information in order to address gaps in equality and diversity information reporting. • Develop in partnership with representatives of local community group processes and information sessions for improving staff collection of equality data / information • Work with patients and carer representatives who access the Trust to assist the Trust in developing its E&D objectives and action plan • Formalise relationship with Local Authority, third sector and other statutory bodies to enable greater sharing of data and intelligence information in relation to equality groups and health inequalities	• Provide training and development opportunities for all staff across the Trust and provide a summary of mandatory and non - mandatory training by ethnic groups providing data for the Trustwide Valuing Peoples Group • The Trust to develop a diverse workforce in the various bandings and attract minority staff across the range of job opportunities and in particular into senior roles. • Develop a range of successful community and staff engagement events and activities that highlight different communities and demonstrate the Trusts commitment to being a personal, fair and diverse organisation • Develop successful Staff Network Groups and a Equality Champions Network that plays a meaningful role within the Trust and local community	• Corporately and locally develop robust partnership working with third sector providers including the sharing of information and intelligence, partnership service delivery and shared training events • Develop leaflets with partnership organisations to ensure they are reflective and meet the needs of our targeted communities and ensure our website is truly reflective of our personal, fair and diverse services we deliver • Invite representatives from the various diverse community to present information and training sessions on issue relating to their specific group, • Support local community events across the Trusts footprint

Underpinning Requirements

The Equality Act 2010 NHS Equality Delivery System (EDS2) Workforce Race Equality Standard (WRES) Care Quality Commission

Behind Schedule	On Target	Action completed

Protected characteristic	Barriers and issues (identified by EDS2 collaborative engagement)	Action	Responsible person	Due by	EDS2 outcome/ Public Sector Equality Duty (PSED)	RAG rating
Disability	Poor access to additional communication support for people with disabilities	Increase the number of patients who inform the Trust that they require additional communication support as defined by the Accessible Information Standard. Actively engage with patients to promote the communication support we can provide, and encourage more patients to 'tell us' what their additional needs are	All staff who have direct with patients Patient Experience Lead Equality Lead Communications Team	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** Sensory group being set up Oct 2019 (Attendees) **1/** National Deaf Children's Society **2/** Southport Deaf Centre **3/** Merseyside Society For Deaf People **4/** Galloways (Blind) **5/** Visual Council **6/** CCG	Ongoing March 2020 Oct 2019

Disability	Poor access to services and poor outcomes for patients who are D/deaf	Work closely with Merseyside Society for Deaf People (MSDP) staff, patients and local Healthwatch groups to ensure that the D/deafness action plan is progressed. Progress to be monitored through the Trusts Patient Experience Group.	Equality Lead Patient Experience Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** Action Plan completed (Deaf) British Sign Language / Subtitled video uploaded on Trust website assist D/deaf people to make a complaint or raise a concern Sensory group being set up Oct 2019	Jan 2020 Ongoing August 2019 October 2019
Disability	Poor access to services and poorer outcomes	Work collaboratively with other providers/CCG to develop guidance around making reasonable adjustments	Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** The Trust is part of the Merseyside Equality Leads and CCG collaboration group reviewing reasonable adjustments	March 2020 Ongoing
Disability	Improve the experience of disabled members of staff in the Trust	Implementation of the Workforce Equality Disability Standard (WDES) in line with timescales provided by NHS England	Assistant Director of HR Governance and Quality	August 2019	4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** The Trust has completed the WDES report and action plan ,	Oct 2019

					scheduled for sign off October 2019 WDES report to be uploaded onto the Trust website	Oct 2019
Disability	Improve the experience of disabled members of staff in the Trust	Set up a staff network for staff with disabilities	Equality Lead	April 2019	4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** Disability Staff Network group to be set up with a date in September /October to meet	Oct 2020 Ongoing
Disability	Improve the experience of disabled members of staff in the Trust	Raise awareness of the support provided for all disabled staff in the Trust by engaging with them in a way they choose	Health & Wellbeing Lead	April 2020	4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** Disability Staff Network group to be set up with a date in September /October to meet. Draft Reasonable Adjustment / Disability Passport compiled and sent out for comment	Oct 2019 August 2019
Gender reassignment	Poor patient experience when accessing services	Work directly with trans patients to better understand what their issues they face when accessing Trust services.	Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination**	

		Review policies and practices to ensure that services are as inclusive as possible			The Trust have the NAVAJO charter mark and are part of the NAVAJO health sub group The Trust has also signed up to the NHS Rainbow Badge Scheme and approximately 650 staff signed up to the scheme in the first 4 week The Trust is part of the Merseyside Transgender Task & Finish Group	March 2020 May 2019 August 2019 Ongoing
Gender reassignment	Poor patient experience when accessing services	Ensure the Trust retains the Navajo Chartermark and develops a robust action plan to ensure improvements are made Develop links with Mermaids Children's Trans Charity	Equality Lead	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 Advance Equality of opportunity and eliminate discrimination The Trust attends the NAVAJO health group Contact Mermaids as part of a information session for staff The Trust is part of the Merseyside Transgender Task & Finish Group	May 2019 Ongoing Oct 2019 Need to contact again July 2019

Pregnancy or maternity/race	Health inequalities and unequal access to maternity services for migrant and asylum seeking women.	Engage directly with migrant and asylum seeking women to better understand the barriers they face when accessing maternity services. Review if/how we can improve current service provision to ensure that their needs are met and barriers to accessing services are removed.	Equality Lead Head of Midwifery	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 Advance Equality of opportunity and eliminate discrimination Need to contact the various local organisations to map who is in the area. Translation and interpretation services a have been reviewed and best practice has been compiled with the CCG and other Equality Trust leads	Oct 2019 May 2019
Race	Cultural sensitivity and patient safety	Work collaboratively with other providers/CCG to develop guidance to ensure the Trust can meet the cultural needs of All protected groups and improve patient safety	Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 Advance Equality of opportunity and eliminate discrimination The Trust has worked in partnership with the CCG and other Trust looking at how to support and meet the needs of the diverse members of the community, The Trust are also a member of the Equal Voice group in Sefton which support members of the	October 2019 Ongoing October 2019

					diverse community i.e. gypsy travellers The Trust are members of the Merseyside & Cheshire Steering Collaboration Group	Ongoing Jan 2020 Ongoing
Race	Improve opportunities for BME staff employed in the Trust	Increase the number of Black and Minority Ethnic Staff in senior leadership roles at Bands 8a and above, closing the gap 1	Assistant Director of HR Governance and Quality	January 2020	WRES 4.1 Advance Equality of opportunity and eliminate discrimination NHS Trust Survey highlights Percentage of BME Trust staff believing that Trust provides equal opportunities for career progression or promotion has seen an increase of 5.4% increase to 80.4% in 2018. . The Trust figures compared to the average combined acute and community Trusts is 8.2% higher for BME staff.	April 2019 Ongoing
Race	Improve the experiences of BME staff employed in the Trust	Improve the results of the three key findings in the staff survey 2018 results for our BME staff % of staff experiencing harassment, bullying or abuse % of staff believing the Trust	Assistant Director of HR Governance and Quality	April 2020	3.3,3.4,3.6,4.1 Advance Equality of opportunity and eliminate discrimination The information for this action is collected for the WRES report the information is in the 2019- 20	March 2020

		provides equal opportunities % of staff experiencing discrimination at work			WRES report and is in the Trust WRES action plan	
Race	Improve the experiences of BME staff employed in the Trust	Reduce the likelihood of BME staff being involved in formal conduct procedures	Assistant Director of HR Governance and Quality	December 2020	3.4,3.6, **Advance Equality of opportunity and eliminate discrimination** The information is contained in the WRES report and action Plan 2018-19 No increase from 2017-18 only 1 BME member of staff went through the process	Sept 2019 Sept 2019
Race/Disability	Poor access to services and poorer outcomes	Approve Translation and Interpretation Quality Standards and ensure that standards are met by any potential providers of interpreting and translation services, including both foreign language and British Sign Language	Head of Procurement Equality Lead	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** The Trust have been a part of a CCG and Merseyside equality leads group that has reviewed the Translation and interpretation services and have set some best practice guidelines	June 2019 Ongoing
Religion and belief	Poor patients experience and outcomes	Work collaboratively with other providers/CCG to develop an action plan around meeting religious and spiritual needs of	Head of Spiritual Care	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity**	

		patients to be implemented across all providers			The Trust chaplaincy service are actively involved with other Trust and have set up a faith group at the Trust	April 2019
Sex	Access to service and poor outcomes linked to sex. Men in particular are less likely to access healthcare services and have poorer outcomes than women.	Identify what we already do in the Trust to support male patients, visitors and members of staff: Working with the Trusts Health and Wellbeing Service and in collaboration with local providers and CCG raise awareness of screening services both in local communities and within the Trust workforce. Provide information on support organisations for those patients, visitors and members of staff living with suicide.	Health and Wellbeing Lead Equality Leads	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 Advance Equality of opportunity and eliminate discrimination	March 2020
Sex/age	Ensure our workforce is representative of the communities we serve	In particular men, the under 25's and the over 60's by 2021	Recruitment Team	December 2020	3.1 Advance Equality of opportunity and eliminate discrimination	March 2020 Ongoing
Sexual Orientation	Poor patient experience when accessing services	Work directly with Lesbian, Gay and Bisexual (LGB) patients to better	Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3	March 2020 Ongoing

		understand what their issues they face when accessing Trust services. Review policies and practices to ensure that services are as inclusive as possible Work with Navajo			**Advance Equality of opportunity and eliminate discrimination** The Trust have the NAVAJO charter mark and are part of the NAVAJO health sub group The Trust has also signed up to the NHS Rainbow Badge Scheme and approximately 650 staff signed up to the scheme in the first 4 week	
Sexual Orientation	Poor patient experience when accessing services	Ensure the Trust retains the Navajo Chartermark and develops a robust action plan to ensure improvements are made	Patient Experience Lead	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** The Trust have the NAVAJO charter mark and are part of the NAVAJO health sub group The Trust has also signed up to the NHS Rainbow Badge Scheme and approximately 650 staff signed up to the scheme in the first 4 week	March 2020 Ongoing
ALL	Poor access and outcomes	Ensure any planned service changes or cost improvement plans consider the Public Sector Equality Duty and health inequalities and carry out the	Director of Corporate Services CIP and project leads	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination**	December 2019

		appropriate level of engagement. Ensure Trust Board and Exec Leads are trained and briefed on lawful decision making and consideration of public law duties.			Equality impact assessment are completed for service change and policies The Trust has reviewed and updated its EIA template and it is out in draft form for comment Schedule sign off December 2019	
ALL	Failure to consult/consider people from protected groups when planning to implement change across the Trust including service changes, cost improvement programmes etc.	Ensure that a robust Equality Analysis is carried out for all cost improvement programmes and service changes by the person(s) planning to implement any changes. Evidence that the Equality Analysis has been considered from the earliest possible planning stages, and includes evidence of consultation where appropriate, discussion and mitigation of any decisions made.	Managers leading on any proposed changes to services/cost improvement programmes	February 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** Equality impact assessment are completed for service change and policies The Trust has reviewed and updated its EIA template and it is out in draft form for comment Schedule sign off December 2019	December 2019 Ongoing
ALL	Poor patient experience when accessing services	Work directly with patients from all protected groups to better understand what their issues they face when accessing Trust services.	Patient Experience Lead Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination**	October 2019 Ongoing

		Review policies and practices to ensure that services are as inclusive as possible			The Trust are actively involved with a number of organisations i.e. Healthwatch and other community groups. The Trust also has a patient experience group and is in the process of setting up a Sensory group	
ALL	Poor patient experience for some protected groups	Develop an engagement plan to ensure that all protected groups are able to engage with the Trust. .	Patient Experience Lead Equality Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination**	April 19
ALL	Cultural sensitivity and patient safety	Work collaboratively with other providers/CCG to develop guidance to ensure the Trust can meet the cultural needs of All protected groups and improve patient safety	Patient Experience Lead	December 2020	1.1, 1.2, 1.3, 1.4, 1.5, 2.1,2.2,2.3,2.4,4.1,4.3 **Advance Equality of opportunity and eliminate discrimination** The Trust has worked in partnership with the CCG and other Trust looking at how to support and meet the needs of the diverse members of the community, The Trust are also a member of the Equal Voice group in Sefton which support members of the diverse community i.e. gypsy travellers	March 2020 Ongoing

ALL	Ensure Trust pays 'due regard' to PSED and health inequalities during unprecedented challenge facing NHS	Executive leads are trained and briefed on lawful decision making and consideration of public law duties.	HR & OD Executive	April 2020	4.1,4.2, 4.3 **Eliminate discrimination** **Advance equality of opportunity** Information presented to the board on the Public sector duty A calendar of training / information sessions is being complied with a roll out date of December 2019	March 2020 Ongoing
ALL	Ensure our workforce is representative of the communities we serve	Review our approaches to staff and volunteer recruitment and retention to: fill any gaps, particularly in difficult to recruit or increased turnover areas like nursing provide opportunities for continuous feedback, improvement of practice and flexible movement within the Trust to help retain staff ensure our processes are fair and equitable for all staff and candidates	HR & OD Executive Recruitment Lead	April 2020	3.1,3.4,3.6, 4.1, 4.3 **Eliminate discrimination** **Advance equality of opportunity** Opportunities for feedback from staff can be provided by the NHS Staff survey, Friends and Family Test, Local Pulse Check Trust has various policies in place to support staff	March 2020 going

ALL	Improve staff health and wellbeing	Improve the wellbeing of all staff and reduce the proportion of staff experiencing stress related illness	Health & Wellbeing Lead	April 2020	3.4,3.5,3.6 **Eliminate discrimination** **Advance equality of opportunity** New supporting attendance policy put in place November 2018 Various health & wellbeing services put in place	September 2019
ALL	Improve development opportunities for staff employed in the Trust	Review our approach to development and talent management to ensure that we 'grow our own' particularly at pay bands 6 and 7 and BME staff	Education Lead	April 2020	3.3,3.6,4.1 **Eliminate discrimination** **Advance equality of opportunity** Talent management programme in place, coaching	September 2019

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**AUDIT COMMITTEE**
MEETING DATE:	**20 JANUARY 2021**
LEAD:	**MR JIM BIRRELL**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- There appeared to be a significant disparity between the Trust's annual contribution to NHS Resolution/Clinical Negligence Scheme for Trusts, approximately £8m, and the anticipated 2020/21 settlements, approximately £2.2m. Given that this was a 'pay as you go' scheme, the figures should be broadly similar so further analysis would be undertaken.
- The report on Cyber Security highlighted several critical risks. A number of these risks were being addressed and should be resolved before the end of March. However, a costed action plan was being produced for the outstanding issues and future progress would be closely monitored by the FP&I Assurance Committee.

ADVISE

- The Terms of Reference for future Internal Audits would, wherever possible, incorporate an assessment of the fitness for purpose of the system to be audited.
- The recently published NAO guidance note on 'Value for Money arrangements under the new Code of Audit Practice' would require External Auditors to produce more detailed and meaningful narrative reports on the relevant systems and processes within a Trust.
- Although there would again be no requirement for External Audit involvement, the Committee was pleased to learn that the Trust would be producing and publishing 2020/21 Quality Accounts.
- The timetable for production of the Trust's annual accounts and annual report has been moved from late May until 29th June.
- In view of current market conditions and the potential disruption involved, it had been agreed that the current contract for the external audit service would be extended for 12 months.

ASSURE

- The Committee considered a range of reports on assurance, including the Board Assurance Framework, (BAF), an assessment undertaken by Assurance Committees Chairs, an assurance map agreed with the Executive Team and the Corporate Risk Register. Taken together it was felt that the collective dataset provided far greater information and assurance than was previously available to the Trust, which, inter alia, should be helpful in compiling the Annual Governance Statement.
- It was noted that the Assurance Committee Chairs' report highlighted a number of comments that would require further consideration during the next iteration of the BAF.
- The Workforce Assurance Committee's deep dive into appraisals was submitted to the Committee. Whilst it was a more detailed piece of work than expected, the findings were very helpful and it had been agreed that it should be considered by the Executive Team with a view to reviewing the Trust-wide approach to appraisals.

• The Committee approved two policy documents - 'Standards of Business Conduct and Managing Conflicts of Interest Policy' and the 'Fit and Proper Person's Policy'.
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

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 FEBRUARY 2021**
Agenda Item	**TB015/21**	**FOI Exempt**	**No**
Report Title	**BOARD ASSURANCE FRAMEWORK (BAF)**		
Executive Lead	Trish Armstrong-Child, Chief Executive		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance Simon Regan, Deputy Director of Quality, Risk and Assurance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The Board Assurance Framework (BAF) provides assurance that the principal risks to achieving the Trust's Strategic Objectives are identified, regularly reviewed, and systematically managed.

Executive Summary

Since presentation at the Board in October, a series of reviews against actions with each executive director were undertaken to ensure there was a clear updated position. Following presentation of this iteration of the BAF at the Audit Committee, each risk linked to the Strategic Objectives was also presented at the respective committee and updated to reflect the comments.

The Board is asked to note that:

- Progress against the individual actions is highlighted in blue to enable easier identification.
- There is no improvement in the current risk scores. However, when taken in context with COVID-19 escalation over the preceding months and the actions still outstanding, this could be anticipated.
- Whilst Target risks have been set for the end of the financial year, any progress/movement in the current risk scores is expected during Q4.

Recommendations

The Board is asked to receive the Board Assurance Framework.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **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:**
Simon Regan, Deputy Director of Deputy Director of Quality, Risk and Assurance	Sharon Katema, Associate Director of Corporate Governance

1. Introduction

1.1. The Board Assurance Framework (BAF) provides a structured process which is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact on the delivery of the strategic objectives.

1.2. During the development and update of the BAF, all executive director leads went through a process of identifying the main sources of risk, balanced against the controls and assurances in place to enable discussion and scrutiny at Board level.

1.3. Assurance is fundamentally about arriving at informed conclusions through robust evidence. The most objective assurances are usually obtained from independent/external reviewers supported by internal sources such as self-assessment and management update reports and KPI monitoring.

2. Background

2.1. Since the last update on the Board Assurance Framework (BAF) to Trust Board, there has been a review with each Executive Director to review progress against actions to ensure a clear updated position as at the end of December 2020.

2.2. The complete version of the BAF was presented at the Audit Committee.

2.3. An overview of the committees aligned to the strategic objectives and risks can be seen in Appendix A.

3. Progress Update

3.1. At the end of December 2020, none of the strategic risks have seen any improvements in the current risk score. However, when taken in context with COVID-19 escalation over the preceding months and the actions still outstanding, this could be anticipated.

3.2. The risk associated with SO3 has been reviewed by the new Interim Director of Finance and some new actions added and re-profiled to fit in with programmes of work.

3.3. Target risks are in place for the end of the financial year and progress/movement in the current risk scores is expected during Q4.

3.4. In addition to receiving the Board Assurance Framework, there is a process to review corporate and operational risks through Risk and Compliance Group and subsequently Board Committees.

Appendix A – BAF Overview

Strategic Objective	Principal Risk	Risk Appetite	Inherent Risk	Current Risk Score as at 31/12/20	Target Risk Score	Lead Committee/ Group	Executive Lead	Direction of travel
SO1: Improve clinical outcomes and patient safety to ensure we deliver high quality services	**Risk ID 1**: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety	**CAUTIOUS**	**16**	**12**	**8**	Quality and Safety Committee	DoN/MD	
SO2: Deliver services that meet NHS constitutional and regulatory standards	**Risk ID 2:** If the Trust cannot achieve its key performance targets it may lead of loss of services	**OPEN**	**16**	**16**	**8**	Finance, Performance and Investment Committee	Dep CEO/COO	
SO3: Efficiently and productively provide care within agreed financial limits	**Risk ID 3:** If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.	**OPEN**	**16**	**16**	**12**	Finance, Performance and Investment Committee	DoF	
SO4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Risk ID 4:** If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience	**OPEN**	**12**	**12**	**8**	Workforce Committee	Dir of HR & OD	
SO5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Risk ID 5:**If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted	**OPEN**	**12**	**12**	**8**	Workforce Committee	Dir of HR & OD	
SO6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Risk ID 6:** There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services	**HUNGRY**	**15**	**15**	**9**	Trust Board	CEO	

Strategic Objective 1: Improve clinical outcomes and patient safety to ensure we deliver high quality services

Assurance Committee: Quality & Safety Committee
Executive Lead: Director of Nursing / Medical Director

RISK ID	1	Risk Description	If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	2	4	8

Risk Description: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

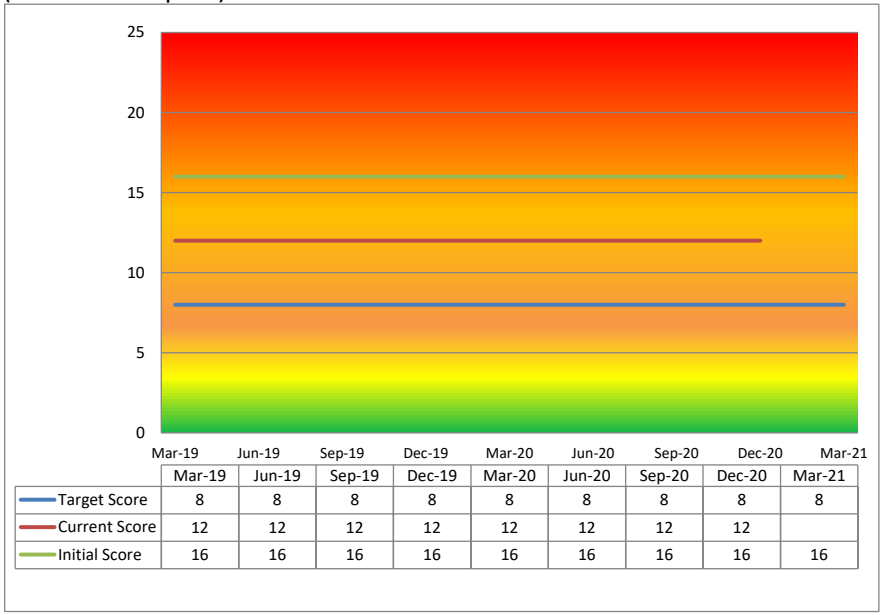
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Governance Structures. 2. Trust policies and procedures. 3. Quality strategy encompassing four priority areas: • Care of the deteriorating patient; • Care of Older People; • Infection Prevention and Control; • Medicines Management. 4. Risk Management Strategy. 5. Risk Management training. 6. Quality impact assessments (QIAs) for all service changes that are considered. 7. Single accountability framework for reviewing CBU areas for development/strengths. 8. KPI dashboards for wards and CBUs in place at key governance meetings. 9. Clinical audit programme /outcomes. 10. Application of clinical pathways and guidelines. 11. Programmes in place for clinical standards and professional practice. 12. Mortality and SJR Process. 13. Work plans for medical staff. 14. Clinical revalidation. 15. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle;	1. Fully established and agreed cycle of business for some governance meetings 2. Non-standardised Trust approach to quality improvement. 3. Clinical workforce strategy not fully developed. 4. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development.	**LEVEL 1** (Operational Management) 1. Quality and Safety Committee 2. Finance, Performance and Investment Committee. 3. Workforce Committee. 4. Health and Safety Committee 5. Risk and Compliance Group 6. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 7. CBU Governance Meetings 8. Harm free care panel 9. Serious Incident Review Group 10. Alert, Advise, Assure (AAA) reports 11. Patient feedback (FFT/Patient Surveys) 12. Clinical audit reports 13. Review of documentation and quality indicators through use of perfect ward. 14. Health and Safety Inspection Programme 15. IPC Board Assurance Framework (BAF) **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): o Mortality metrics o Never events o Incident data o Serious Incidents o CQUINS o Performance data o Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. SONASS ward accreditation programme 7. VitalPac deterioration measures	1. CQC 'Must and should do' actions not addressed in full. 2. Consistent reporting of key KPI's. 3. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests and audit. 4. Medical examiners and medical examiner's office not fully established. 5. Nurse establishment review not yet complete.	1. KPI dashboards for wards and CBUs to be reviewed, including visibility at key governance/committee meetings. – **Action Completed –** ward and CBU dashboards routinely shared at PIDA, CBU governance and reported to Quality and Safety Committee monthly from Oct-20. 2. Cycle of business to be reviewed for Trust-wide and CBU governance meetings. – **Action Completed –** Reviewed cycles of business for clinical effectiveness committee, CBU governance, risk and compliance group – updated versions being rolled out. 3. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– By end March 2021** 4. Clinical workforce strategy to be completed **–** ~~by end of March 2021.~~ **Revised to end of Dec-21.** 5. Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed. – ~~By end of November 2020.~~ **Revised to end of Mar-21.** 6. Risk management training with senior leaders in the organisation **– Action Completed:** Training with all CBUs and Corporate in Nov-20 and ongoing mop up training continues (Dec-20 and date planned Jan-21). 7. Complete CQC Must and Should Do actions – **By end of Jan 2021.** 8. Review KPIs that goes to all governance meetings – **By end Mar 2021.** 9. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. **– By end of Jan 2021.**

		• 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. 16. Training programme (mandatory and non-mandatory). 17. CQC action plan to address areas of underperformance highlighted on inspection. 18. Quality Visits/Senior Walkabouts including focus on Patient Safety 19. Supervision and education of clinical staff across all professions. 20. Application of Patient Safety and other safety alerts. 21. Patient Safety Specialists appointed.		**LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits 4. CQC Insight Report 5. CQC Outlier Alerts 6. CQC engagement meetings 7. Healthwatch 8. National Audits 9. Peer Reviews and accreditation. 10. Getting it right first time (GIRFT) programme. 11. NHSI/E oversight meetings 12. Quarterly and Annual Guardian of Safe Working Report. 13. CCG monthly quality and performance meetings 14. Internal/External Audit 15. Quality Account		10. Complete the full roll-out/reporting of Perfect Ward app measures **– Action Completed:** Perfect Ward dashboards established and reporting process developed. 11. Review health and safety/fire risk assessment/audit programme – **Action Completed:** H&S Inspection Programme agreed at H&S Committee in Dec-20. 12. Complete appointments to medical examiners roles and fully establish programme to review all deaths **– by end of Feb 2021.** 13. Appoint patient safety specialist **– Action Completed:** 2 x Patient Safety Specialist Appointed – plan to have full time appointment from Apr-21 and training programme led by NHSE/I. 14. Nurse establishment review to be completed – ~~By end of October 2020 and every six months thereafter~~ **Revised to Jan-21:** delayed due to COVID-19 but to be presented at Workforce Committee in Jan 2021 and then Trust Board in Feb-21. In line with cycle of business thereafter. 15. PIDA, agreed suite of measures in place. **- COMPLETE** 16. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. **- COMPLETE**
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge					

AMBITION: To improve clinical outcomes and patient safety to ensure we deliver high quality services

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	**The Trust is willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 6	Comments
Risk Rating: Initial 4 x 4 = 16 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	a) 1862 – Safe Staffing b) 2122 – Medicines Management c) 2056 – Missing Patient appointments d) 1688 – Inadequate staffing within Anaesthetics e) 2052 – Older People's Care f) 1902 – CQC compliance	**Update – January 2021** • The strategic risk and associated linked risks have been reviewed and this remains a high risk. • Since the BAF was last updated, six actions have been completed on time. Three actions have seen the target date revised; two of these are interdependent with other strategic risks and have been amended to fit in with programmes of work. • It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objectives. • Key focus in the next quarter will be building on the work undertaken in the last three months to continue to strengthen and improve governance and risk management arrangements at Trust and CBU level.



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	12	12	
Initial Score	16	16	16	16	16	16	16	16	16

Risk Description: If the Trust cannot achieve its key performance targets it may lead of loss of services

Strategic Objective 2: Deliver services that meet NHS constitutional and regulatory standards

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Chief Operating Officer

RISK ID	2	Risk Description	If the Trust cannot achieve its key performance targets it may lead of loss of services

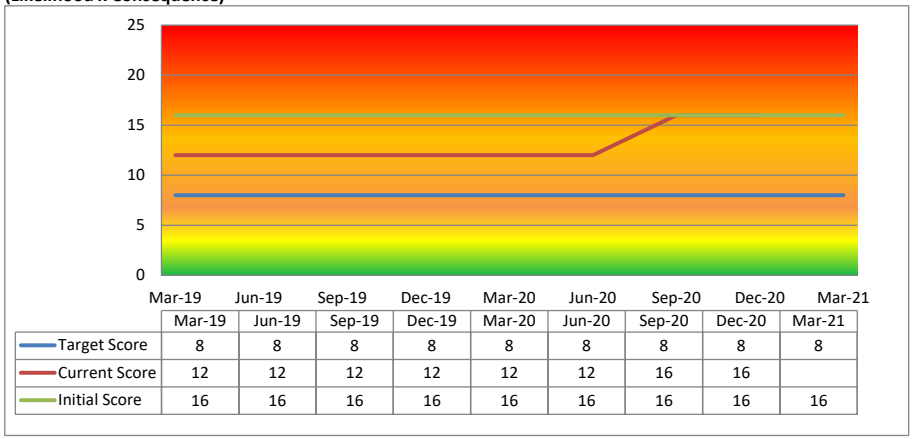
Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it may lead of loss of services **CAUSE** Lack of clear vision for transformation and partnership working in fragile services; inability to recruit in certain medical specialities; year on year rise in demand for urgent and emergency care; capacity and demand; flow through the hospital; system discharge challenges; COVID-19 impact – causing delays in discharge, elective, diagnostic and cancer pathways. **CONSEQUENCE** Delays in the provision of care and treatment resulting in poor patient outcomes and standards of care; over-reliance on temporary workforce leading to increasing prevalence of fragile services; failure of national performance target (cancer, referral to treatment (RTT); failure to reduce delayed transfers of care; failure to deliver NHS constitutional targets; duplication of services with negative impact on CIP; impact on patient experience; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Shaping care together programme. 2. Southport and Ormskirk Improvement Board. 3. Southport and Ormskirk Admissions and Discharge Working Group. 4. North Mersey A&E Delivery Board. 5. Single accountability framework for reviewing CBU areas for development/strengths. 6. Part of C&M hospital cell group monitoring COVID-19 recovery and sharing capacity where possible. 7. Bronze, silver, gold command structure for oversight and decision making. 8. Weekly Senior Operational Leadership Team (SOLT) meetings 9. Agreed in-hospital winter plan 2020/21. 10. Directorate Manager role that is solely responsible for Access - providing greater strengthen in governance and compliance. 11. Quality impact assessments (QIAs) for all service changes that are considered. 12. Trust policies and procedures updated in line with SITREP requirements / guidance against the constitutional standards. 13. Use of Quality Improvement (QI) Methodology to ensure any service improvement	1. The workforce of the Trust does not have the sufficient level of expertise to ensure QI methodology can be applied; 2. Non-standardised Trust approach to quality improvement. 3. Clinical workforce strategy not fully developed. 4. Partnership working not fully established in all fragile services. 5. Insufficient economies of scale to deal with social distancing / workforce impacts arising from COVID-19.	**LEVEL 1** (Operational Management) 1. Finance, Performance and Investment Committee. 2. Operational Performance & Improvement Group (OPIG) oversees work against the four operational priorities: o Theatre Utilisation; o Patient Flow improvements; o Operational productivity; o Cancer wait improvements. 3. Quality and Safety Committee 4. Workforce Committee. 5. Risk and Compliance Group. 6. Clinical Effectiveness committee; 7. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 8. CBU Governance Meetings. 9. Local IPRs in place to monitor performance. 10. Performance Manager in post supporting internal assurance that the Trust complies to SITREP guidance against constitutional standards. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): o Mortality metrics o Never events o Incident data o Serious Incidents o CQUINS o Performance data o Complaints and compliments 2. Quarterly report to FP&I on progress against each key constitutional standard to offer assurance in	1. Not always delivering the 95% standard of all patients presenting to ED being seen, treated and discharged / transferred within 4 hours. 2. During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard. 3. Not consistently delivering the national standard due to workforce challenges across a number of tumour groups in particular Haematology and Head & Neck services.	1. Develop an Integrated Performance Report that allows the Trust to measure improvement and understand variation, taking on best practice set by regulatory bodies. - **COMPLETE** 2. Introduction of a Single Accountability Framework - **COMPLETE** 3. SOPs developed for validation processes that are signed off by the COO - **COMPLETE** 4. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– By end March 2021** 5. Out of hospital winter plan **Action Completed** – approved out of hospital (system) winter plan agreed. 6. Clinical workforce strategy to be completed **–** ~~by end of March 2021.~~ **Revised to end of Dec-21.** 7. Engage system partners and agree sustainability plans for fragile services **– by end of March 2021.** 8. Risk management training with senior leaders in the organisation **– Action Completed:** Training with all CBUs and Corporate in Nov-20 and ongoing mop-up training continues (Dec-20 and date planned Jan-21). 9. Develop sustainable plan to address validation issues in relation to the non-RTT tracker. **– Action Completed:** Plan and Business Case approved at Trust Board and approach endorsed by NHSE/I. Partial recruitment completed. 10. Develop local IPRs for CBUs **– COMPLETE – in place from end of July 2020.**

	becomes sustained and embedded. 14. Clinical prioritisation. 15. Access policy for validation of all patients on waiting lists. 16. Use of additional locations to provide treatment where possible. 17. Risk Management Training 18. Agreed out of hospital (system) winter plan 2020/21. 19. Plan to address non-RTT tracker.		actions being taken to maintain and / or improve performance **LEVEL 3** (Independent/Semi-Independent) 1. NHSI Single Oversight framework and monitoring arrangements 2. CQC 3. CCG monthly quality and performance meetings. 4. NHS benchmarking data. 5. Getting it right first time (GIRFT) programme. 6. Cancer alliance oversee delivery and performance regarding cancer metrics. 7. Internal Audit 8. External Audit. 9. Peer review boards		11. Recruitment for a Performance Manager post – **Completed:** Started in post November 2020. 12. Develop peer review boards – **Completed:** Peer assessments now in place across the system.
The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To give every person the best care every time and deliver our operational performance standard

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 2 x 4 =8 **(Likelihood x Consequence)**  	a) 1987-Haematology/ Oncology service b) 1688-Anaesthetic staffing c) 2056 – Missing Patient appointments/admissions	**Update – January 2021** • The strategic risk and associated linked risks have been reviewed remain extreme. • Since the BAF was last updated, five actions have been completed on time; one action has seen the target date revised, which is interdependent with other strategic risks and has been amended to fit in with programmes of work. • At the last formal update, the risk was upgraded to extreme which was predominantly associated with: o Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment. o Fragile services; o The unresolved issue of non-RTT tracker and potential associated impact on patients. • One of these issues has been moved forward significantly since the last update as a plan in relation to the non-RTT tracker issues has been developed and agreed by board and partial recruitment has taken place. • It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objectives. • Up until Dec-2020, the Trust were 2nd best performing Trust for elective restoration (including endoscopy) and this has reflected positively on the recovery in constitutional standards.

	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	16	16	
Initial Score	16	16	16	16	16	16	16	16	16

Risk Description: If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.

Strategic Objective 3: Efficiently and productively provide care within agreed financial limits

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	3	Risk Description	**If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.**

Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	3	4	12

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question. **CAUSE** Fluctuating income and activity; Inability to deliver the required levels of CIP; inability to control agency costs and premium payments to support fragile services; insufficient liquid cash to meet expenditure obligations on a monthly basis; capital cost estimations are higher than originally predicted. **CONSEQUENCE** Shortfall in funding (PSF/FRF); reductions in services or the level of service provision in some areas; potential loss in market share; regulatory intervention; lack of financial stability; missed opportunities to invest in services and new technologies; failure to deliver the capital programme.	1. Financial Systems and processes. 2. Scheme of Reservation and delegation 3. Standing financial instructions 4. Budget holder training. 5. Short term financial plan for the Trust. 6. Cheshire and Mersey Health Care Partnership (HCP) 5 year plan 7. Business Development and Investment Group (BDIG) approves all business cases and reports to FP&I Committee. 8. Capital Investment Group 9. Strategy Task and Finish Group 10. Shaping care together programme 11. Health Trust Europe (HTE) Procurement Framework 12. Cheshire and Mersey Framework 13. National Agency Team Support 14. People Activity Group (PAG) 15. 2020/21 Cost improvement (CIP) programme commenced and indicative plan for 2021/22. 16. Smart sheet software from PMO. 17. e-Rostering 18. Financial Management Framework 19. Use of Resources Action Plan in place.	1. Due to COVID-19 unable to accurately forecast the Trust's income. The temporary arrangements for 2020/21 will eventually come to an end but there is no clarity on the future of the Payment by Results (PbR) tariff. 2. Currently no financial recovery plan that delivers break-even/ services the underlying deficit. 3. Lack of three year medium term financial model, taking into account current position and savings from any reconfiguration in line with Sefton Transformation Board Strategy. 4. E-rostering system not fully utilised across the Trust.	**LEVEL 1** (Operational Management) 1. Finance, Performance and Investment Committee 2. Audit Committee 3. Hospital Management Board 4. Business Development and Investment Group (BDIG) 5. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 6. Model Hospital Group 7. Trust Board 8. Detailed agency spend reviewed by Efficiency Programme Group (EPG) 9. Monthly CIP review meetings 10. Monthly cash flow forecast **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report (IPR) 2. Monthly financial position reports/CIP Reports to HMB, FP&I Committee and Board 3. Activity and performance reports **LEVEL 3** (Independent/Semi-Independent) 1. NHS England/Improvement 2. CQC 3. CCG 4. Internal Audit 5. External Audit 6. National Agency Team reports	1. Inability to monitor trajectory against financial recovery plan until developed. 2. Robust tracking of CIP programme. 3. High level forecasting is a manual driven process.	1. Implement robust financial governance framework – **Action Completed** – financial management framework approved through HMB (03/12/20). 2. Develop scenario-based approach to business plan/budget setting for 2021/22 taking account of the COVID-19 trajectory and emerging financial arrangements for 2021/22 – **by end of March 2021** 3. Develop and commence implementation of strategy for the roll out of patient level costing to inform clinical understanding of cost drivers – **by end of February 2021** 4. Develop financial framework to underpin Shaping Care Together programme, setting out affordability and potential financial improvement/recovery **– by end of March 2021** 5. Develop reporting mechanism to track progress with financial improvement recovery plan – **by end of March 2021.** 6. Internal audit review of CIP programme **–** ~~by end of March 2021.~~ **Revised to Q2 2021/22:** to fit in with the embedding of the new actions included. 7. Commence CIP programme **– Action completed** – 2020/21 CIP programme was commenced 01/10/20 and indicative 2021/22 CIP targets have been shared with CBUs and Corporate functions. 8. Establish process for identifying, implementing and monitoring delivery of efficiency/productivity (CIP) **– by end of February 2021.** 9. Develop Use of Resources action plan **–** **Action completed** – Use of Resources Action Plan agreed at Trust Board in November 2020.

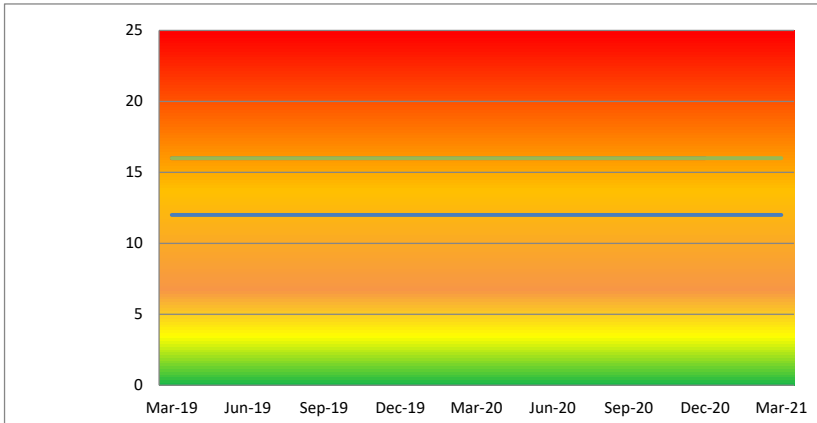
						10. Implement and report progress against the Use of Resources action plan **– report to FP&I Committee by end of March 2021.** 11. E-rostering to be fully rolled out in all areas **– by end of March 2021.** 12. NHS Shared Business Services developing a new forecasting and budgeting tool **– to be tested by end March 2021 with aim to use in 21-22 financial year.**
The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge						

AMBITION: To provide care efficiently and productively, within agreed financial limits

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING

Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 3 x 4 =12
(Likelihood x Consequence)



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21
Target Score	12	12	12	12	12	12	12	12	12
Current Score	16	16	16	16	16	16	16	16	
Initial Score	16	16	16	16	16	16	16	16	16

Linked Risks: 2

1942: Eradicating Trust deficit by 2023/24
1688: Anaesthetic staffing

Comments

Update January 2021

- Despite the financial performance during 2020/21 year to date the risk remains extreme
- There were three actions completed on time. The new Interim Director of Finance has undertaken a review of the BAF and identified three new actions (2,3 and 8) which have been added and re-profiled three actions to make them clearer (actions 4,5 and 10 above). The date for one action (6) has been changed to fit in with programmes of work.
- Due to COVID-19 a new financial framework resulted in a break-even position through top up for the first six months of the financial year.
- In the second half of the year the Trust is planning to deliver a £1.7 million deficit although it is currently forecasting £1.3 million deficit.
- Although the financial performance in 2020/21 represents a significant improvement this is being driven by non recurrent resources aligned to a temporary financial framework during the COVID pandemic.
- There is uncertainty surrounding the contracting and financial framework in 2021/22 but it is highly likely that the Trust's underlying deficit remains at a level that results in this risk remaining extreme.

Risk Description: If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

Assurance Committee: Workforce Committee
Executive Lead: Director of HR and OD

RISK ID	4	Risk Description	If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience

Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	12	3	4	12	2	4	8

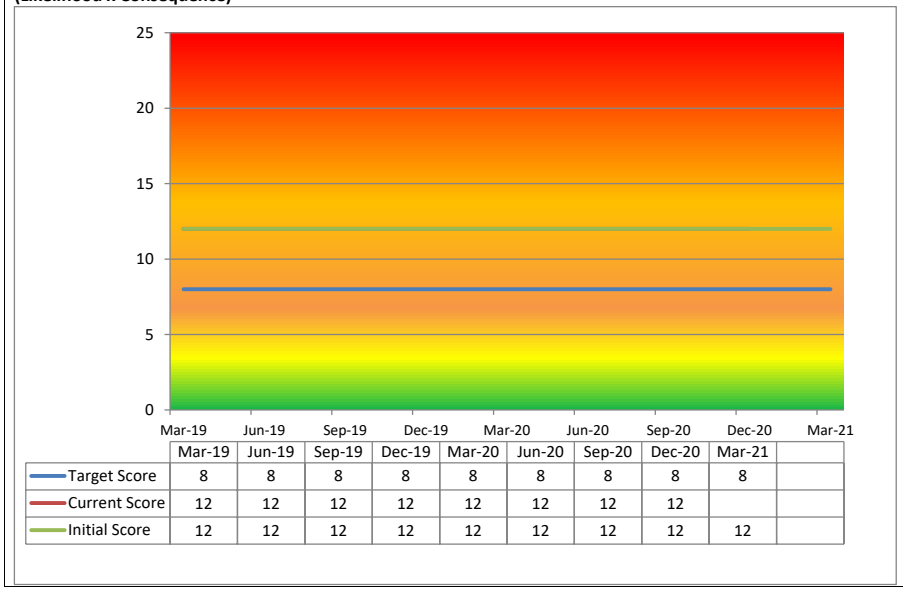
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient	1. Workforce and OD Strategy 2. Recruitment & Retention Strategy (Linked to Trust and NHSI Nursing Retention Programme). 3. Trust policies/procedures 4. Recruitment processes including Right to Work and DBS checks (as indicated). 5. Coaching Strategy 6. Overseas Recruitment Campaign for Nurses 7. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. 8. Job plans for medical staff. 9. Corporate staff induction 10. Training programme (mandatory and non-mandatory). 11. PDR process 12. Clinical revalidation. 13. E-Rostering 14. Ward/departments non-medical staffing position is controlled through: o 3 x daily at staffing huddle; o 7 day staffing matron in place for oversight and management; o Weekly staffing review and sign off; o Roster sign off meeting. 15. Communication and Engagement Strategy and Plan 16. People Activity Group (PAG)	1. Workforce and OD Strategy does not yet reflect NHS People Plan 2. Lack of a fully developed and scoped Clinical Workforce strategy. 3. Recruitment & Retention Strategy needs to be reviewed. 4. In need of earlier identification of junior doctor rota gaps and proactive block booking to address. 5. Possible delays in international recruitment due to host countries not releasing staff due to COVID-19 pandemic and isolation requirements. 6. E-rostering system not fully utilised across the Trust 7. Training Needs Analysis' (TNAs) are not all validated to individual area and assigned competencies for specialist subjects are in need of review.	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the four operational priorities: o Job Planning o PDR's / Appraisals o Mandatory Training 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. Mandatory training; 3. PDR completion; 4. Sickness rates. 5. Absence Data 6. Turnover Data 7. Vacancy Rate 8. Time to Hire monitoring and reporting. 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual 11. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC	1. Sickness absence above target but improved 2. Low compliance rates for PDR completion 3. Time to hire is longer than 30 day target (however better than regional and national median)	1. Workforce and OD strategy reviewed and rolled out **– by end of March 2021** 2. Clinical workforce strategy to be completed **–** ~~by end of March 2021.~~ **Revised to end of Dec-21.** 3. Review recruitment and retention strategy **–** ~~by end of Jan 2021 –~~ **Revised to end of Mar-21.** 4. Early liaison with Lead Employer and progression to fill gaps by Trust at easiest opportunity – **review end March 2021** 5. Health and Wellbeing action plan in place, requires alignment to the NHS People Plan **- by end of March 2021** 6. Incorporate Lead Employer liaison into the recruitment team and establish a process to get early notification of shortages in the junior doctor rotation programme **– to be complete by end of December 2021** 7. Monitor guidance about travel and isolation for international recruitment of nurses **– COMPLETE and monitor ongoing.** 8. E-rostering to be fully rolled out in all areas **– by end of March 2021.** 9. Training Needs Analysis (TNA) and clinical competency deep dive underway led by the Director of Nursing, Midwifery and AHPs **– to be completed by end of March 2021.** 10. Monitor sickness levels through integrated performance report and respond where appropriate - **ONGOING** 11. Deep dive into PDR/Appraisal Process **– Action complete** - presented to Workforce Committee – Dec-20 12. PDR Action planning with CBU's **- Action complete –** trajectories in place and monitored at PIDA

	confidence in provision of services.	17. The Big Brew staff engagement programme. 18. 'At our Best' Leadership development programme 19. Supporting attendance policy.		3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		13. Ongoing monitoring and review of time to hire process with month on month reduction being achieved. Identification of potential causes of delay. Reports to Workforce committee. **– to aim to achieve time to hire target by end of March 2021.** 14. Develop an action plan in response to PDR deep dive **– by end of March 2021.**
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Merseyside and Lancashire

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce	**Update – January 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • Since the BAF was last updated, two actions have been completed on time. • It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objectives. • The Workforce and OD Strategy or 'Our People Plan' has been reviewed, bringing together all key people related programmes of work in one place for the first time. • The revised Workforce and OD Strategy has meant other enabling strategies, processes and timescales of each programme of work have been revisited. In addition, associated governance arrangements, impacting on the delivery of some programmes of work against the BAF have also been reviewed which has resulted in the amendment of two of the target dates and an additional action being added. • Existing programmes of work will continue to be implemented, with a further plan of key deliverables over the next 2 years.



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	12	12	
Initial Score	12	12	12	12	12	12	12	12	12

Risk Description: If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

Assurance Committee: Workforce Committee
Executive Lead: Director of HR and OD

RISK ID	5	Risk Description	If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	12	3	4	12	2	4	8

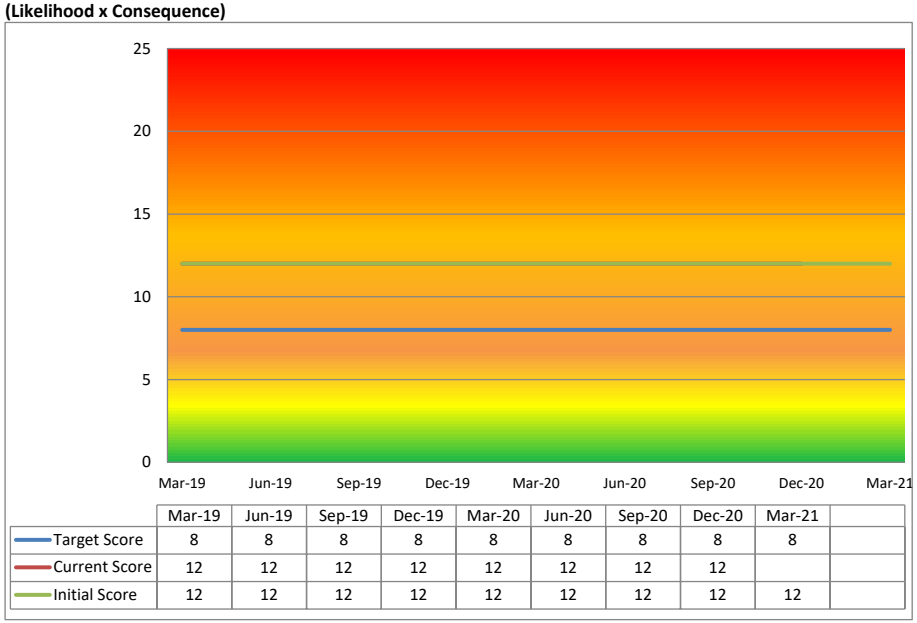
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours; leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Workforce and OD Strategy 2. Underpinning strategies: o Leadership Strategy 2019-2021 o At our Best programme re-launched Sept 2020 o Coaching o Staff engagement 3. Recruitment & Retention Strategy (Linked to Trust and NHSI Nursing Retention Programme). 4. Trust Values & Behaviours Framework in development 5. 'At our Best' Leadership Development Programme 6. 'Being our Best' management development sessions 7. Trust policies/procedures 8. Value of our People Group 9. Single accountability framework to measure success of leaders and areas for improvement. 10. Equality Strategy 11. Equality, diversity and inclusion networks in place. 12. Processes for raising/investigating concerns 13. Freedom to speak up guardian 14. Joint negotiating committee (JNC) 15. Staff Engagement approach adopted – The Big Brew. 16. Bespoke team developments based on values & behaviours	1. Workforce and OD Strategy does not yet reflect NHS People Plan. 2. Recruitment & Retention Strategy needs to be reviewed. 3. Re-launch of Trust Values and Behaviour Framework, delayed due to COVID-19. 4. Succession Planning – not fully in place. 5. Talent management - no capacity to deliver TM approaches with effective outcomes 6. Pause of Board Development sessions due to COVID-19. 7. Insufficient visibility of Executive Team and Non-Executive Directors due to limitation caused by COVID-19 and social distancing.	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): o Mandatory training; o PDR completion; o Sickness rates. 2. Turnover; 3. Vacancies; 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG	1. Staff Survey Engagement score not significantly improved in year and remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address relatively poor engagement with Equality, diversity and inclusion networks.	1. Workforce and OD strategy reviewed and rolled out **– by end of March 2021** 2. Review recruitment and retention strategy ~~– by end of Jan 2021~~ **Revised to end of Mar-21.** 3. Launch new Staff Charter ~~by end of November 2020~~ **Update:** The staff charter is in place but the launch is being re-aligned to be launched at the same time as the values and behaviours framework **by the end of April-21.** 4. Trust Values and Behaviours Framework launch in line with new appraisal process **– by end of April 2021** 5. Review approach to succession planning for critical roles **– to be completed by April 2021** 6. Re-start leadership and development activity **–** **Action completed** – Leadership Development Activity re-started October 2020. 7. Medical leadership programme to be restarted using funds from NHSI. **– to run from January to July 2021** **Update:** 7 x workshops for 28 Consultants & SAS Doctors who will gain 25 CPD points for full attendance and have access to a mentoring network, BMJ Journal and FMLM online resources throughout the programme. 8. Re-start board development sessions ~~– by end of October 2020 and ongoing.~~ **Update:** These had been delayed but commenced in August 2020. Future board development sessions are planned following discussions at the Strategy Session in January 2021. However, this has now been

		17. Access to NHS Leadership academy Programmes & 360 feedback 18. Mandatory and role specific training programme in place 19. Appraisals – policy and process. Personal development review (PDR) and training form part of this. 20. Apprenticeship programmes leadership & management offer Levels 3-7 21. Apprenticeship Steering Group – bi-monthly 22. Board visibility through: o Back to the floor sessions; o 15 steps walkabouts in wards/departments 23. Board Development sessions planned throughout the year 24. Leadership development activity re-started following COVID-19 pause. 25. Medical leadership programme re-started following COVID-19 pause.		4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		superceded by current guidance from NHSI. 9. Re-start back to the floor sessions – ~~by end of October 2020 (COVID-19 permitting).~~ **Update:** Where possible, Executive colleagues (Director of Nursing, Midwifery and Therapies, and Director of HR & OD) have engaged in back to the floor sessions and were reinstated in Dec-2020. 10. Re-start 15 steps board walkabout programme – ~~by end of October 2020 (COVID-19 permitting).~~ **Update:** Remain on hold due to COVID-19 restrictions. 11. Initiate reporting on staff survey as an assurance mechanism **– Action completed** – Reported to Workforce Committee in Nov-20. 12. Develop and implement staff survey engagement plan to engage staff after the staff survey has been completed – **Action completed** – Reported to Workforce Committee in Nov-20. 13. Deep dive into PDR/Appraisal Process **– Action complete** - presented to Workforce Committee – Dec-20. 14. Review of E,D&I engagement with networks to agree an approach to increase engagement **– to be completed and presented at WIG** ~~by end of December 2020~~ **In absence of WIG - revised to be presented to Workforce Committee in Mar-21.** 15. Develop an action plan in response to PDR deep dive **– by end of March 2021.**
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Cheshire & Merseyside

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**		**Update – January 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • Since the BAF was last updated, four actions have been completed on time. • It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objectives. • The Workforce and OD Strategy or 'Our People Plan' has been reviewed, bringing together all key people related programmes of work in one place for the first time. • The revised Workforce and OD Strategy has meant other enabling strategies, processes and timescales of each programme of work have been revisited. In addition, associated governance arrangements, impacting on the delivery of some programmes of work against the BAF have also been reviewed which has resulted in the amendment of four of the target dates and an additional action being added. • Existing programmes of work will continue to be implemented, with a further plan of key deliverables over the next 2 years. • Some actions related to Board visibility have been delayed due to the continuing COVID-19 restrictions.



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	
Target Score	8	8	8	8	8	8	8	8	8	
Current Score	12	12	12	12	12	12	12	12		
Initial Score	12	12	12	12	12	12	12	12	12	

Risk Description: There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Assurance Committee: Trust Board
Executive Lead: Chief Executive

RISK ID	6	Risk Description	There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Inherent Risk			Risk as at 31/12/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	5	15	3	5	15	3	3	9

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services **CAUSE** Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire; lack of system-wide workforce planning to address the issues around qualified staff pipeline over the next 5 years and current speciality specific emerging workforce gaps; lack of Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach; challenges around working across two ICS/STP footprints; lack of clarity about additional capital funding support at CMHCP/NHSE/I level to enable emerging scenarios to address sustainability challenges; lack of public engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** Clinical unsustainability due to current and projected workforce gaps as well as activity outweighing capacity; financial unsustainability due to costs significantly outweighing	1. Robust system governance in place, including: o Southport, Formby & West Lancs Programme Board: Shaping Care Together o Shaping Care Together operational groups: Delivery Group and Communication & Engagement Group o Southport, Formby & West Lancashire Clinical Leaders Group o Sefton Provider Alliance 2. Robust internal governance in place, including: o Hospital Improvement Board (HIB) - leading Vision 2020 and Single Improvement Plan 3. Southport and Ormskirk Improvement Board (SOIB) - leading Vision 2023 4. Documentation in place: o Finalised and agreed Shaping Care Together (SCT) programme plan for delivery o KPMG Case for Change o Sefton 2gether o West Lancs Building for the Future o Acute Sustainability Vision and Design Principles o Cheshire and Mersey sustainability and transformation partnership (STP) plan. 5. Whole system engagement from health, social care, voluntary, community and faith sectors (VCFS) partners to be able to address whole system change. 6. Quality and equality impact assessments completed and	1. Clear alignment between Shaping Care Together programme and System Management Board. 2. Lack of established Patient & Public Reference Group.	**LEVEL 1** (Operational Management) 1. Trust Board 2. Finance, Performance and Investment Committee. 3. Quality and Safety Committee 4. Workforce Committee 5. Risk and Compliance Group 6. Clinical Effectiveness Committee 7. Vision 2020 agreed at Board, updated version now in development 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. Ongoing review and management of 'fragile services'. 10. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board. 11. Patient and public engagement strategy monitored at Programme Board. 12. Equality Impact Assessment outcomes monitored at programme board. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. CEO's reports to Board 2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: o Mortality o Incident data o CQUINS o Operational performance data o Complaints and compliments 3. Single Improvement Plan reports to Improvement Board 4. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group **LEVEL 3** (Independent/Semi-Independent)		1. Reporting of progress monthly internally to Trust Board via HMB, and externally to SOIB. – **COMPLETE and ongoing** 2. Establish reporting line into the newly set up CMHCP/NHSEI Oversight Group – **Action complete and ongoing** 3. Develop, implement, embed and review Communication and Engagement Strategy and Plan with an effective patient and public forum. – **Action complete:** Strategy and Plan complete, public engagement commencing 11/01/21 4. Production of an agreed SCT Programme Plan to include key milestones to enable public consultation - **Action complete:** Roadmap and full programme plan through to implementation (2025+) complete and monitored through programme governance 5. Southport, Formby & West Lancashire Clinical Strategy development aligned with organisational strategic directions and emerging solutions from the engagement work **to be complete by end of August 2021.** **Update:** Clinical and Care Congress (CCC) replaced Clinical Leadership Group to provide quality assurance 6. Strategic Partnership criteria, principles and framework to be developed in line with engagement approach to ensure transparent and robust partnerships developments that may be required to address sustainability challenges ~~to be complete by end of December 2020.~~ **Revised to end of May-21** - approaches developed, seeking legal advice from NHSEI and CMHCP related to incorporating partnership

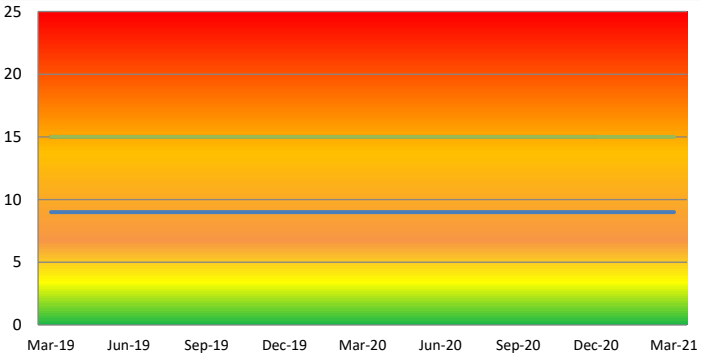
	income; poor estate utilisation due to inability to fully reconfigure services; unsustainability of a standalone organisation to continue to deliver acute services for the population; potential impact on neighbouring organisations and services if core acute services can no longer be delivered by the Trust.	reviewed before any changes to Trust service provision. 7. System Equality Impact Assessment process established.		1. Southport, Formby & West Lancashire Joint Committee 2. Southport & Ormskirk Improvement Board - meets monthly. 3. Cheshire & Mersey Health & Care Partnership (CMHCP): Strategic Oversight Group (reporting line) 4. Sefton Provider Alliance. 5. West Lancashire Multi-speciality community partnership (MCP). 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. CCGs 10. Internal Audit 11. External Audit.		and collaboration discussion earlier in the process 7. System wide Equality, Health Inequality and Quality Assurance process to be established – **Action Complete:** Equality Impact Assessment process established. Health Inequalities assessment in progress – seeking travel impact assessment expertise to support, System Quality Impact Assessment will be managed by CCC. 8. Programme to be monitored internally through Trust Board – **Action complete and ongoing**
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve

Category	AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING

Risk Rating: Initial 3 x5 = 15 Current 3 x 5 = 15 Target 3 x 3 =9
(Likelihood x Consequence)



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	
Target Score	9	9	9	9	9	9	9	9	9	
Current Score	15	15	15	15	15	15	15	15		
Initial Score	15	15	15	15	15	15	15	15	15	

Linked Risks: 3

1942: Eradicating Trust deficit by 2023/24
2072: Failure to achieve 2019/20 financial control total
1688: Anaesthetic staffing

Comments

Update – January 2021

- The strategic risk and associated linked risks have been reviewed and this remains a high risk.
- Since the BAF was last updated, five actions have been completed on time and the programme of work associated with Shaping Care Together has set out and is monitored with clear governance arrangements. One action has seen the date revised.
- It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objective.
- The Board have discussed this strategic objective and determined that moving forward, SO6 will be monitored at Trust Board monthly as opposed to Hospital Management Board (HMB).
- Public engagement commenced on 12th January 2021 with the key focus in the next quarter to be on continued engagement with the public and staff.

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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 February 2021**
Agenda Item	**TB016/21**	**FOI Exempt**	**No**
Report Title	**CORPORATE RISK REGISTER**		
Executive Lead	Bridget Lees, Executive Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant Director Integrated Governance		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

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

Executive Summary

Currently there are four extreme risks to the organisation, three of which relate to the Covid-19 pandemic and are reviewed weekly by the Leads and Gold Command. The fourth risk relates to Fragile services and work remains ongoing with this risk via an overarching action plan:

- The action plan is progressing with a focus on those services that require immediate mitigation to reduce the fragility. All services have been RAG rated following mitigation in both the immediate and mid-term time periods; this is reviewed regularly with the operational ADOs and progress shared with the relevant sub-committee.
- The system QIPP schemes are progressing that support the fragile services with a focus on Ophthalmology; Dermatology; Cardiology and Haematology, regular reports are in place to the System Management Board. Further system wide discussions are planned to take place when the current Covid-19 surge has reduced.

Recommendation

The Board of Directors are asked to **note** the risk register.

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:**
Mandy Power	Bridget Lees

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Board/Sub-Board Committee: Trust Board Risk Register

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO3 - Efficiently and productively provide care within agreed financial limits SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire					**Link to BAF**		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
29/04/2020	2220	Steve Christian	Steve Christian	Covid 19 - Constitutional access standards					
Description	Failure to achieve constitutional access standard caused by the global COVID 19 pandemic resulting in non compliance for RTT, Diagnostics, Cancer and ED performance								
Controls	Follow national EPRR guidance for cancer, elective and emergency activity All current patient referrals are being prioritised due to clinical need via risk stratification based on Royal College Guidance 2WW referrals continue as normal. All routine new patient referrals are being risk stratified to determine clinical urgency Delivering required OP activity through different methods such as face to face for those requiring, telephone consultations and piloting virtual clinics using Attend Anywhere across a number of specialties. Theatre lists maintained for cancer and clinically urgent cases Maintaining monthly reporting for each external standard. Safely maximise productivity of OP, Theatres and endoscopy to deliver as much activity as possible prior to winter as per Phase III response. Restart the staff redeployment piece which will be crucial to backfilling absence however may not have the same effect given the drive to achieve Phase III activity						**Gaps in Controls**	Some weekly reporting reduced as per guidance Some variation in risk stratification documentation - new Covid-19 appropriate SOP being developed	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Almost Certain (5)	Major (4)	20	20	Extreme risk	4	Moderate risk	21/01/2021	28/01/2021
Assurance							**Gaps in Assurance**		
Action Plan							**Action Plan Due Date**		**Action Plan Rating**

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Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO4 - Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
18/03/2020	2201	Jane Royds	Sonya Clarkson	Covid - 19 Workforce	
Description	Failure to provide adequate staffing caused by absence relating to Covid 19 resulting in resource challenges and an increase within the temporary staffing domain.				
Controls	24.03.2020 Executive briefing twice daily (Officially known as Gold, previous Exec Briefings)) 09.03.2020 Incident hub set up for control and command (Silver) 18.03.2020 Operational meetings held daily (Bronze to feed into Silver) 09.03.2020 Twice daily staff sitreps (enhanced for Covid-19) 16.03.2020 Strategy working at home 16.03.2020 Competency upskill training being developed 09.03.2020 Work with external partners and agencies for the clinical provision of bank and locum staff (enhanced for Covid-19) 23.03.2020 Health and well being advice in place to support staff while in work. 02.03.2020 Covid 19 screening for health workers who are displaying symptoms 09.03.2020 Generic staff plan in place for movement of staff into critical areas as and when required 20.04.2020 Re-deployment tool drafted to support silver/gold command staff redeployment requirements 23.03.2020 Training programme in place to upskill staff 23.03.2020 Resuscitation training theory update training available. 23.03.2020 Staff with up to date resus training in the Trust, Outreach and crash team available to attend if resuscitation required 20.03.20 Sit rep return for non clinical staff sickness in place 27.04.20 Letter shared with HRD to send to BAME members of staff 30.04.20 Risk assessment updated to include BAME staff. 01.05.20 CEO supported by the Equalities Lead met with a number of BAME staff to discuss any concerns, support and action taken to reduce and mitigate the risk. 08.05.20 CBU's instructed by gold command to assign appropriate individuals to undertake BAME risk assessments and deliver letter from CEO. 02.06.2020 Empactis unplanned absence line is launched within the Trust to support the timely reporting of unplanned absence. 14/09/2020 Individual reviews of all sickness absence cases being undertaken with the CBU HR Business Partners and Advisors and staff side lead to ensure cases are being appropriately managed and support is being provided. 14/09/2020 Sickness absence overall continues to reduce month on month according to the latest data. 05/11/2020 Launch of incentive scheme for staff to cover nursing shifts and development of a projected workforce situational report to aid proactive redeployment and shift reconfiguration decisions 12/11/2020 Absence increasing due to covid (non covid decreasing) and 80 clinical staff deemed 'clinically extremely vulnerable'. Incentive scheme has increased take up of shifts and safe staffing projection tool launched 12.11.20 to aid better planning. Too early to assess impact of both these additional controls. 26/11/2020 Absence rate reducing slightly, clearly impacted by staff deemed 'clinically extremely vulnerable' who are due to return from 3rd December. Welfare calls planned to aid return. Incentive scheme has increased take up of shifts, as well as new bank doctors rates and safe staffing projection tool launched and is aiding better planning of backfill requirements 04/01/2021 Absence rate increasing again alongside 3rd wave, increase in no. due to covid and non related covid reasons. Deep dive being undertaken with report due to GOLD on 06/01/21. Impact of attendance also anticipated due to new Tier 4 restrictions in Lancashire.	**Gaps in Controls**	24.03.2020 Practical aspects of resuscitation training not being delivered

Southport and Ormskirk Hospital NHS Trust

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review	
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	04/01/2021	28/01/2021	
Assurance	Clinical staff sitreps Incident hub set up for control and command (Silver) Sitrep reports being discussed at the twice daily Executive meetings (Gold HR sitrep twice daily to PHE and NHSEI HR sitrep twice daily to PHE and NHSEI Non clinical staff sitreps QIA for Paeds medical staff in place for changes in rota's						**Gaps in Assurance**			
Action Plan	Training programmes to be developed for identified critical area Sitrep report to be developed for non clinical critical support areas						**Action Plan Due Date**	30/04/2020 30/04/2020	**Action Plan Rating**	Completed Completed

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Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO5 - Enable all staff to be patient-centered leaders building on an open and honest culture and the delivery of the Trust values					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
15/10/2020	2286	Bridget Lees	Andrew Chalmers	Nosocomial and bed spacing during covid 19 pandemic				
Description	With the current COVID-19 pandemic there is a requirement that 1. Patient's need to be socially distanced by 2 meters to decrease the risk of transmission. Wards 7a/b, 11a/b, 10a/b and 9a/b the distance between the beds between 1.4 and 1.5 meters. 2. Patients who acquire Covid while in hospital are investigated to ensure actions are taken to prevent further infections.							
Controls	15.10.2020 Patients required to wear supplied masks when able 15.10.2020 Furniture rearranged to put lockers together and not chairs together. 15.10.2020 Extraneous equipment such as visitor chairs are removed to give the patients more space. 15.10.2020 Review process in place of all patients who acquire Covid 19 while in hopital 15.10.2020 Covid swabbing taking place on admission of all patients and at 5 day intervals. 15.10.2020 Quality matrons and Deputy Director of Nursing are reviewing the bed spaces on the wards and providing instruction. 25.11.2020 3 day swabbing being implemented effective 25.11.2020. Risk Assessment in place in regards using beds in smaller wards. Patients to wear masks if at all possible. 01.12.2020 Inter patient screens to be installed - expected to start week commencing 7.12.2020 with small wards at Southport as priority. 14.01.2021 7S, 9S, 10S, 11a COMPLETED. 11b Covid ward. Majority of wards have tracks installed across both sites. Issue currently is around supply of curtain material. Weekly progress monitored with estates and Silver. 21.01.2021 7s, 9s, 10s, 11a, 14a, 14b, Ward 1 completed. 11B, 15A, 15B covid wards						**Gaps in Controls**	Physical limitation of the available space while attempting to maintain the same bed capacity. Patient masks have to be removed when eating and drinking. Privacy curtains can restrict additional obseravations of pateint required additional observation. When patients mobilise then the distance between patients can further diminish.
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	10	High Risk	21/01/2021	28/01/2021
Assurance	15.10.2020 Infection prevention and control meetings monitoring covid cases. 15.10.2020 Operational covid meetings 15.10.2020 Silver and Gold Trust meetings in place National Guidance From PHE and NHSEI. Monitoring of covid case reported in hospital through NHSEI Reporting and monitoring of covid cases through Public Health England Outbreak meetings held for all outbreak within the Trust						**Gaps in Assurance**		
Action Plan	Reviewing screens between beds Reviewing the current surge plan						**Action Plan Due Date**	01/03/2021 10/12/2020	**Action Plan Rating** Moderate Progress Made Completed

Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire				Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**			
21/05/2020	2230	Chief Operating Officer	Donna Lynch	Fragile Services			
Description	There is a risk that the trusts clinical services become increasingly difficult to deliver (fragile) and that clinical outcomes are compromised due to unwarranted variation, fragmentation of services and sub-scale specialties. In this case the definition of Fragile is those clinical services provided by S&OHT which are a cause for concern due to workforce shortfalls or excessive financial cost; and are in danger of not being able to be sustained (time period to be quantified by clinical service. The main clinical services that meet this definition are Haematology, Pain, Dermatology, Older People Services (Geriatricians), Anaesthetics, Radiology, General Medicine, Head & Neck, Stroke, Community Paediatrics, Dietetic services, Ophthalmology and Acute Medicine						
Controls	diagnostic phase for all Trust services underway and presented at PIDA The Trust has formally declared at Trust Board ongoing challenges in delivering safe and consistent clinical services mainly are attributed due to workforce pressures. This has triggered formal acknowledgement and dialogue with NHS England and other NHS providers to determine & consider next steps. This is progressing with System Management Group to review pathways to minimise risk. Closure of referrals Haematology, Pain, Dermatology – minimise impact to patients An over reliance in using temporary workforce solutions (i.e. agency and outsourcing) across the 14 fragile clinical services which is adversely affecting the expenditure bill of the Trust and more importantly increases the variation in clinical practice; and therefore risk in delivery of efficient, responsive and effective services. The introduction of the System Management Board / Group for Southport & Formby and West Lancashire to determine any possible system transformation between secondary and primary care to look at alternative models of care that support improving resilience and accessibility of clinical for the local population. Introduced targeted recruitment campaigns to support strategies to influence the market forces including targeted work in specific areas.. Formal discussions have commenced for short term support Formal discussions have commenced for strategic support - exec to exec for Haematology and Cardiology Fragile Services review has commenced - CBU sessions took place in september with the outputs presented at PIDA NED involved in the methodology for FS review commenced - paper sent for comments - follow up discussions at September FP&I				**Gaps in Controls**	As continue through the different phases of Covi-19 the Trust will continue to experience staffing issues which will continue to impact Trust fragile services. The Trust needs agreement on the formal links with other NHS providers to commence robust clinical dialogue in achieving sustainable models for the local population. At this moment without this direction the Trust is working through ad-hoc arrangements with multiple NHS providers without any clear MOU and / or mandate. This makes engagement at all levels challenging. The COO has initiated a System Management Group with CCG leads to review local solutions against a number of the fragile services. The conversations are positive however the main risk here is that those services defined as fragile at the Trust are indeed that service lines that other local NHS providers are also experiencing some difficulties with.	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	05/01/2021	05/02/2021
Assurance	Each of the 14 clinical services has individual risk assessments (including mitigating actions) that are monitored at each CBUs Governance meetings and escalated through to the Risk & Compliance Group. The risk assessments are also reviewed at the CBU PIDA Boards which oversees the Trust Single Accountability Framework which ensures those mitigation actions are progressing and supported. The Trust is actively engaging formal support from NHS England – the solution to acute sustainability is being managed through the Shaping Care Together programme. The Trust is actively in dialogue with other local NHS providers and CCG to review mutual aid and alternative models of care between current secondary and primary care providers across the local health economy NEDs involved in CBU planning process Outputs of diagnostic will, where relevant, link into the SMG QIPP schemes where alternative service provision is being developed to include mutual aid / regional service provision / formal partnership arrangements				**Gaps in Assurance**	Many of the fragile services are indeed related to workforce pressures which are national issues however compounded greatly at the Trust due to size and workforce numbers. October review identified a number of recruitment pieces that address in part some specialities including the use of insourcing . skill mix review, new roles etc	

Action Plan	To develop a consolidated action plan for all Fragile Services. Delivery against the action plans identified through the SMG QIPP Programme; Dermatology, Ophthalmology, Haematology and Cardiology	**Action Plan Due Date**	27/11/2020 30/04/2021	**Action Plan Rating**	Completed Moderate Progress Made