AGENDA
BOARD OF DIRECTORS' MEETING

To be held at 0930 on Wednesday 07 April 2021

V = Verbal D = Document P = Presentation

Ref N°.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
TB038/21 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	5 mins
TB039/21 (V)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*DoN*	10 mins
TB040/21 (D)	**Declaration of interests** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB041/21 (D)	**Minutes of the previous meeting** *Purpose: To **approve** minutes of the meeting held on 3 Mar 21*	No	*Chair*	5 mins
TB042/21 (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				**0950**
TB043/21 (D)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*5 mins*
TB044/21 (D)	**Chief Executive's Report** *Purpose: To **receive** an update on key issues from the CEO*	*No*	*CEO*	*10 mins*
COVID-19 UPDATE				**1005**
TB045/21 (P/D)	**Covid-19 Update** a) Covid-19 Update b) Infection Prevention Control Assurance Framework *Purpose: To **receive** the Covid-19 Update*	*No*	*Execs* *DoN*	*20 mins*

INTEGRATED PERFORMANCE				**1025**
TB046/21 (D)	**Integrated Performance Report (IPR) Summary** *Purpose: To **note** the IPR for assurance.*	*No*	*CEO / DCEO*	
QUALITY & SAFETY				**1025**
TB047/21 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report b) Quality and Safety Performance Report *Purpose: To **receive** the reports for information and assurance*	*No*	*Cttee Chair DoN/MD*	15 mins
TB048/21 (D)	**CQC Progress Report** *Purpose: To **note** the CQC Progress Report*	*No*	*DoN*	5 mins
OPERATIONS AND FINANCE				**1045**
TB049/21 (D)	**Finance, Performance and Investment** 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 COO IDoF*	20 mins
WORKFORCE				**1105**
TB050/21 (D)	**Workforce Reports** a) Committee AAA Highlight Report *b)* Workforce Performance Report *Purpose: To **receive** the reports for information and assurance.*	*No*	*Cttee Chair DoHR MD*	10 Mins
TB051/21 (D)	**Annual Staff Survey** *Purpose: To **receive** an update on the Annual Staff Survey*	*No*	*DoHR*	10 mins
RISK AND GOVERNANCE				**1125**
TB052/21 (D)	**Board Assurance Framework** *Purpose: To **approve** the BAF*	*No*	*ADCG*	10 mins
TB053/21 (D)	**Corporate Risk Register** *Purpose: To **receive** the Corporate Risk Register*	*Yes*	*ADCG*	5 mins
TB054/21 (D)	**Board of Directors Annual Workplan 2021/22** *Purpose: To **receive** and **approve** the Cycle of Business*	*No*	*ADCG*	5 mins

ITEMS FOR INFORMATION			
CONCLUDING BUSINESS			**1145**
TB056/21 (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*
TB057/21 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*	*Chair*	*3 mins*
TB058/21 (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 05 May 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

Board of Directors Register of Interests as at 01 April 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
GORRY, Mrs Julie	Non-Executive Director	Nil	Nil	Nil	Nil	Specialist Adviser CQC (2015 to date) NHS Professionals-Public Health England (2020 to date) Project Adviser: Hospice of the Good Shepherd (2017 to 31 January 2021)	Nil	Nil	02-Feb-21

Board of Directors Register of Interests
as at 01 April 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
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)	Nil	Nil	04-Jan-21
HANKIN, Dr Terrence	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
MASOM, Mr Neil	Chairman & Non-Executive Director	JSSH Ltd NDLM Ltd The Foundry (Loughborough) Management Company Ltd	Nil	Nil	Seashell Trust	Nil	Nil	Nil	27-Jan-21
POLLARD, Mr Graham	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Employed by Royal Agricultural University	15-Mar-21
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 Stephen	Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Board Trustee – Age Concern Central Lancashire	05-Feb-20

Board of Directors Register of Interests
as at 01 April 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
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	Nil	Honorary Professorship with Bolton University	28-Jan-21

Draft Minutes of the Board of Directors' Meeting
Held on Microsoft Teams
Wednesday 03 March 2021
(Subject to the approval of the Board on 07 April 2021)

Members Present

Mr Neil Masom	Chair
Mrs Trish Armstrong-Child	Chief Executive
Mr Jim Birrell	Non-Executive Director
Dr David Bricknell	Non-Executive Director
Mr Steve Christian	Deputy Chief Executive/ Executive Director of Strategy
Mrs Julie Gorry	Non-Executive Director
Mr Bill Gregory	Interim Director of Finance
Dr Terry Hankin	Executive Medical Director
Ms Bridget Lees	Executive Director of Nursing, Midwifery and Therapies
Mr Graham Pollard	Non-Executive Director
Mr Steve Shanahan	Executive Director of Finance *(Part 2 only)*
Mr Gurpreet Singh	Non-Executive Director

In Attendance

Rev Martin Abrams	Hospital Chaplain and Freedom to Speak Up Guardian *(Item TB031/21)*
Mr Tony Ellis	Communications and Marketing Manager
Mrs Pauline Gibson	Non-Executive Director Designate
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB021/21	**Patient Story**	
	Ms Lees introduced the patient story which provided an insight to the experiences of Poppie, a 6-year-old patient that has regularly attended hospital due to her complex needs. Rosa, Poppie's mum, outlined that whilst the care received has been good there have been occasional challenges due to their location and challenges around continuity of care. She added that as most of Poppie's consultants were based at Alder Hey Children's Hospital the family would prefer to receive care locally as they had built up positive relationships with staff at the Trust. The Infection Prevention and Control measures introduced at the Trust during the Covid-19 pandemic, meant that for patients receiving treatment within the wards, some of the facilities like the bath, playroom and parents' room were not accessible. The story highlighted the challenges that families with young children with complex needs faced and following on from this story the playroom was risk assessed and subsequently re-opened.	

DRAFT

Mr Masom thanked Rosa and Poppie for sharing their story and commented that he appreciated the bravery of a parent telling the story.

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

TB022/21 Chair's Welcome and Note of Apologies

Mr Masom welcomed all in attendance. There were no apologies for absence.

TB023/21 Declaration of interests

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

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

TB024/21 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 03 February 2021 and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board **approved** the minutes from the previous meeting.

TB025/21 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

STRATEGIC CONTEXT

TB026/21 Chair's Report

Mr Masom presented the report which detailed the activities undertaken since the previous meeting. The report provided an update in relation to the following:

- North West Regional Chairs' Meetings
- Covid-19 Update
- Nurse recruitment
- Charitable Funds

RESOLVED:

DRAFT

The Board **received** the Chair's update

TB027/21 Chief Executive's Report

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

- Thanks A Bunch award was presented to Ms Lauren-Jade Otto for her work in organising the Trust's Covid-19 vaccination programme.
- The Irritable Bowel Disease Team had a poster presented at the Health Education England Advancing Practice Conference
- The SO Proud Award was presented to ward manager Gayle Haney

With regards to Covid-19 it was noted that:

- There had been a reduction in the number of inpatients with Covid-19 in line with community rates
- The Trust would remain at Surge Level 3 despite a reduction in critical care demand occupancy which has remained high
- The vaccination programme has delivered 8,559 vaccines of which 79.2% of substantive staff had been vaccinated. The Vaccination team were validating data to ensure they captured all staff including those vaccinated at other sites.
- The team had also started to roll out vaccinations to some of the inpatients based in the Spinal Injuries Unit.
- The recently established Discharge Task Force has been on site seven days a week resulting in a 32% reduction of super-stranded patients in January.
- Discussions on The Shaping Care Together Programme had continued with local residents and community groups. Drop-in sessions for staff have also been arranged.
- Following an annual review by the Cheshire and Mersey Major Trauma Network, the Trust's status was confirmed for a further 12 months.

RESOLVED

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

COVID-19-19 UPDATE

TB028/21 Covid-19 Update

a) Covid-19 Update

Mr Christian introduced the Covid-19 Executive Team update which provided an overview of the current situation.

Dr Hankin advised that there has been an increase in ED attendances in the over 60 age group when compared to the previous year which has had an impact on length of stay (LoS).

Mrs Royds and Ms Lees jointly presented the update on Staff Wellness and Welfare and highlighted the following:

DRAFT

- Feel Good February has been launched with activities planned for each day of the month.
- 13 Wellbeing Guardians volunteers had been appointed with 10 Wellbeing Champions currently in place
- The Organisational Development (OD) Team has been visiting the wards to provide coaching support
- Eight places had been secured on the REACT Training – (Recognise, Engage, Actively listen, Check risk, Talk about specific actions) which would assist staff to have meaningful Mental Health discussions
- A Toolkit of Rainbow Resources, which included a range of activities, was now in place on the Staff Zone

It was noted that the Vaccination Team had now extended invitations to Cohort 5 (65 to 69 year olds) and immediate relatives of staff have been invited to book an appointment.

With regards to testing, it was noted that Lateral Flow testing has been extended to include non-clinical staff whilst patient facing staff would now be transitioning to the Loop-mediated Isothermal Amplification (LAMP) testing from 15 March. The LAMP tests would be undertaken once a week and it would not be necessary for staff to report their results or arrange a confirmatory PCR test if they tested positive.

Mr Gregory presented an update on the financial position and corporate developments advising that spend during the second and third waves of Covid-19 had not been significantly different to the spend during non Covid-19 times. There had been a peak in nursing costs during June 2020 that was attributed to appointing trainee nurses into senior Health Care Assistant posts.

The Information Management and Technology (IM&T) as well as the Estates and Facilities teams had played a key role during the previous 12 months and highlights included:

- The roll out of the Attend Anywhere software that provided an opportunity for video consultations with patients
- The provision of equipment which allowed remote and agile working including installation and implementation of MS Teams for all virtual meetings
- Upgrade to Medical Air at the Ormskirk site
- Closer working between Estates and Facilities and the Nursing team ensuring compliance with Infection Prevention and Control (IPC) measures to minimise infections such as enhanced cleaning and installation of screens between beds.
- Supporting the establishment of the Vaccination Hub within the Corporate Management Office (CMO)

Mr Christian advised that there had been a reduction in the number of Emergency Department (ED) attendances for minor injuries and illness.

DRAFT

However, there had been a 4% increase in major attendances during the same period resulting in a slight increase in emergency admissions. The benefits of the NHS 111 service were evident as this provided alternative options for members of the community to receive treatment in non-hospital settings.

The Trust was able to offer mutual aid at a system level despite facing operational challenges during the third wave. The decision to suspend all non-urgent elective work was justified and managed proactively.

In response to Dr Bricknell's question around excess deaths during the first wave, Dr Hankin advised that it would be too early to comment and that there was growing evidence coming out of the statistical work that these might be referred to as earlier than expected deaths.

Mrs Gorry commented on the choice of staff wellness and welfare options available and queried whether sufficient time had been factored in for staff to access these options during working hours. Mrs Royds advised that this was dependent on individual need. However, some staff were accessing the options when off duty. In response to Mr Singh's question Mrs Royds advised that she couldn't advise the uptake in terms of numbers and which options had been accessed the most but would present this information at Workforce Committee once available.

Mrs Gibson requested a summary as well as assurance at Workforce Committee around the work that has been carried out to measure the impact of Covid-19 on the absence rates.

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 a progress update and overview of the Trust's performance against the measures within the report. She advised that work was progressing on schedule for the 24 items outlined and added that systems and processes were in place to manage and monitor IPC guidance and identify risks.

In response to Dr Bricknell's question around whether this level of reporting should be reviewed regularly by Board, Ms Lees advised that it was a NHSE requirement and that the current reporting level would need to remain in place for the foreseeable future.

Mrs Gorry questioned whether the installation of the screens on the wards would have an impact on the communication and isolation of elderly patients. Ms Lees advised that the team had considered this and had sought to mitigate

DRAFT

the impact during the design phase of the project. Ms Lees added that a report on the impact on elderly patients would be presented to the Quality and Safety Committee. Furthermore, Mrs Armstrong-Child advised that a patient story around this topic would be presented at a future Board meeting.

ACTION: A report on the impact of the installation of screens on communication and isolation of elderly patients would be presented at the Quality and Safety Committee. **DoN**

ACTION: A patient story around this topic would be presented at a future Board meeting. **DoN**

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

INTEGRATED PERFORMANCE

TB029/21 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 during January 2021.

It was noted that the Ward Dashboard matrix, which contained a set of KPI's relating to the 5 CQC domains, was currently being refined and would be included in future reports. In addition, a review of the IPR was underway to ensure that the indicators were aligned with national targets. Once completed, the proposed amendments would be presented for consideration at the Executive Team Meeting (ETM).

RESOLVED:
The Board **noted** the IPR Summary Report.

QUALITY AND SAFETY

TB030/21 Quality and Safety Reports

a) Committee AAA Highlight Report

Dr Bricknell presented the AAA highlight report following the Quality and Safety Committee meeting held on 22 February 2021 and highlighted the following:

- Three alerts were noted at the meeting relating to:
  - The Lost to Follow Up programme has been progressing and no further moderate or serve harms have been discovered. However, the recruitment plan that had been approved at Board has been delayed due to Covid-19. Mr Masom commented that this was not an area of overdue concern as risk stratification has been completed and Mrs Armstrong-Child provided assurance that this has been identified as an operational matter and would be discussed at ETM and the Quality and Safety Committee.

DRAFT

- The risks associated with each element of Fragile Services would be routinely reviewed by the Committee together with the mitigations.
- The slight increase in the Summary Hospital-level Mortality Indicator (SHMI) was anticipated and reflected the national Covid-19 reporting guidance and post discharge high mortality.

- The Committee took assurance from the Maternity team who advised that the Trust was progressing with the required actions from the Ockenden report and the information that the Trust was no longer a national outlier on the National Joint Registry.

It was noted that, due to an error, the AAA Highlight report that has been included in the meeting pack would be updated.

RESOLVED:
The Board **received and noted** the AAA Report from the Quality and Safety Committee.

b) Quality and Safety Performance Report

Ms Lees presented the Quality and Safety Performance report which provided an overview of the Trust's performance against the quality and safety standards. It was noted that Safe staffing had declined in month due to the impact of the third wave of Covid-19.

RESOLVED:
The Board **noted** the Quality and Safety Performance Report.

TB031/21 Freedom to Speak up Guardian Quarterly Reports (Q2 & Q3)

(Rev Abrams joined the meeting)

Rev Abrams presented the reports which provided an overview of concerns raised to the Freedom to Speak up Guardian (FTSUG) during Q.2 and Q.3. The Freedom to Speak up Champions have continued to provide support and to play a pivotal role within the service.

In response to Mr Birrell's question around the percentage of complaints from Allied Health Professionals (AHP) staff that has been noted in the report, Rev Abrams provided reassurance that these issues were of a short-term nature and had been resolved.

Mrs Gorry queried the numbers around the themes of bullying and harassment and Rev Abrams advised that this was a part of the speaking up process and that there were a high number of staff members reporting a perception of bullying. Work on what was acceptable or not within the Trust has been delayed due to Covid-19. Mrs Gibson commented that it was a positive step forward

DRAFT

that bullying and harassment were being reported. It was agreed that the work around bullying and harassment would need to be incorporated within the Trust's People Plan.

RESOLVED:
The Board **received** the Freedom to Speak up Guardian reports

(Rev Abrams left the meeting)

OPERATIONS AND FINANCE

TB032/21 Finance, Performance, and Investment (FPI)

a) Committee AAA Highlight Report

Mr Pollard presented the key issues highlight report following the meeting held on 22 February 2021 and drew attention to the following:

- Three Alerts were noted at the meeting relating to:
  - An updated forecast that incorporated the revised estimates for the cost of annual leave carry forward and non-NHS income totalling £3.5m had been received.
  - All providers across the Cheshire and Merseyside had been asked to contribute to the Sustainability and Transformation Plan (STP) economy deficit.
  - The Trust had moved to Level 3 status for critical care during January which resulted in the utilisation of 18 beds in comparison to the contracted 11 critical care beds.

- The Committee was assured by the establishment of a working group had which included commissioning colleagues and sought to progress options required to address the Trust's three most fragile services. This programme would be taken forward under the CCG Vulnerable Services Policy

RESOLVED:
The Board **received and noted** the AAA Report from the FP&I Committee.

b) Operational Performance Report

Mr Christian presented the Operational Performance Report which provided a summary of operational activity against the constitutional standards and highlighted the following achievements:

- 98.4% of patients had been on the waiting list for less than 6 weeks for radiology scans
- During December, the Trust has treated 86 patients on the cancer 62-day referral to treatment pathway which was the second highest number recorded in a single month.

RESOLVED:
The Board **noted** the Operational Performance Report

c) Financial Performance Report

Mr Gregory presented the Financial Performance report which detailed performance against financial indicators for January 2021. The report outlined that:

- The percentage of Agency staff (cost), whilst showing failing assurance was showing positive variation, and had decreased marginally in January.
- The pay run-rate, non-pay run rate and bank/agency run rate were all showing negative variation with further increases in January, most significantly the Bank & Agency Run Rate, which had breached the 3rd control limit in January due to the effect of the third wave of Covid-19 on medical and nurse staffing.
- The current financial agreements had impacted on most measures, so assurance and variation were not entirely representative in this section of the report.

RESOLVED:
The Board **noted** the Financial Performance Report

d) Director of Finance Report

Mr Gregory presented the Finance Report which provided the Board with a summary of the financial position as of January 2021 advising that monthly expenditure levels had increased due to higher Covid-19 expenditure as well as the payments made in respect of the nurse incentive scheme. It was noted that these costs would be covered by the Covid-19 funding that the Trust has received.

During month 10, which was at the peak of the third wave of Covid-19, there has been an increase in the run rate for staffing. However, this has not impacted on the overall figures. There was a continued loss of non-NHS income, but the Trust has received confirmation that they would be receiving the funding to cover this.

RESOLVED:
The Board **noted** the Director of Finance Report

WORKFORCE

TB033/21 Workforce Committee

a) Committee AAA Highlight Report

Mrs Gibson presented the AAA highlight report from the meeting held on 23 February 2021 and drew attention to the following:

- Safe Nurse Staffing - the Committee was assured that there was an ongoing plan in place to mitigate any risks.

DRAFT

- Medical recruitment – there has been a reduction in the vacancy rate and improvements have included increasing the number of search agencies to support identification of suitable applicants as well as improving the Trust's recruitment marketing material.
- There has been an increase in compliance of PDRs and the Appraisal Deep Dive Analysis will be presented at ETM for sign off.
- The Trust's sickness absence rates had remained high and generally static and the Business Intelligence (BI) team had been working with HR to develop an interactive dashboard to provide a more systematic approach to improving trajectories.
- The Trust welcomed an additional 11 nursing colleagues from overseas

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

b) Workforce Performance Report

Mrs Royds presented the Workforce Performance Report which provided an overview of performance against the workforce indicators during January 2021. She advised that the increase in bank and agency spend related to the nurse bank incentive scheme as well as Covid-19 related expenditure. Time to hire has shown an improvement in the month but was still under target. It was noted that the Recruitment team had 72 new starters in January 2021 and were also involved in the onboarding of 37 new nurses.

RESOLVED:
The Board **noted** the Workforce Performance Report.

c) Safe Nursing and Midwifery Staffing Report

Ms Lees presented the Safe Nursing and Midwifery Staffing Report which provided a comprehensive update on nurse and midwifery staffing. The report included an overview of the work that had been undertaken to ensure staffing levels were safe and sustainable.

The report highlighted the following:
- The commencement of International Recruitment (IR) and the recruitment of 70 international nurses
- Collaborative working and recruitment planning with local universities which had resulted in an additional 82 students being placed with the Trust
- Despite Covid-19 there has been positive movement around vacancies in Urgent Care

RESOLVED:

DRAFT

The Board **received** the Safe Nursing and Midwifery Staffing Report for information and assurance

ITEMS FOR INFORMATION

TB034/21 Committee Minutes

The Board received the minutes of the following Committees:

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

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

CONCLUDING BUSINESS

TB035/21 Questions from Members of the Public

Noting that no questions have been received from members of the public, Mr Masom encouraged members of the public to submit questions 48 hours in advance of the meeting as this enabled the Board to respond to views and concerns of the patients and the local community to remain at the heart of Board discussions.

TB036/21 Message from the Board

The Board agreed the messages to be circulated across the organisation and noted the request to ensure there was focus on the Workforce directorate over the next few months.

TB037/21 Any Other Business

In any other business, Dr Bricknell commented that he would like to receive feedback from the overseas nursing recruits around their experiences since joining the Trust.

Mrs Gorry asked whether it would be possible to include patient stories on the website as these could be of interest to members of the public viewing the Trust's website.

In response to Mr Singh's query it was advised that the staff survey results would be presented at the next Workforce Committee meeting and then at Board. It was noted that the results were embargoed until 12 March.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:13

DRAFT

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*							✓	✓	✓	✓	✓	✓
Bill Gregory										✓	✓	✓
Julie Gorry	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓
Terry Hankin	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Therese Patten	✓	✓	✓	✓		✓						
Graham Pollard	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Steve Shanahan	✓	✓	A	A		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												

**became a voting member of Board*

DRAFT

Board of Directors (Part 1)

Matters Arising Action Log

Action Log updated 01 April 2021

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 **February Update:** Included on Agenda **March Update:** Defferred to April 2021 due to operational pressures. **March Update:** The report will be presented at Quality and Safety Committee meeting in March and thereafter to Board. **April Update:** Report included on Part 2 of Agenda	Yellow
TB028/21	03-Mar-21	**b) Infection, Prevention and Control Assurance Framework**	Mrs Gorry questioned whether the installation of the screens on the wards would have an impact on the communication and isolation of elderly patients. Ms Lees advised that the team had considered this and had sought to mitigate the impact during the design phase of the project. Ms Lees added that a report on the impact on elderly patients would be presented to the Quality and Safety Committee. Furthermore, Mrs Armstrong-Child advised that a a patient story around this topic would be presented at a future Board meeting	**DoN**	01-Mar-21	02-Jun-21	**March Update**: Ms Lees to present a report on the impact of the screens on the communication and isolation of elderly patients at Quality and Safety Committee	Green
				DoN	01-Mar-21	02-Jun-21	**March Update:** A Patient Story around the impact of screens on elderly patients to be presented at a future Board meeting.	Green

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB043/21	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 seeks to appraise the Board of Directors of the Chair's activity since the last Board meeting held on 3 March 2021, in relation to: • North West Regional Chairs' Meetings • Changes to the Board • Charitable Funds
Recommendations
The Board is asked to **receive** the Chair's Report.
Previously Considered By:

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

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

Prepared By:	Presented By:
Sharon Katema, Associate Director of Corporate Governance	Neil Masom, Trust Chair

1. Introduction

1.1 This month, I begin by extending my personal thanks and gratitude to all our teams for the sterling work they continue to do as we continue in the recovery phase in response to the Covid-19 pandemic.

1.2 I have witnessed the pressures and challenges that both our clinical and non-clinical staff have faced and am acutely aware of how hard they have all worked in the last 12 months.

2. Staff Survey

2.1 On our agenda today, the Board will be considering the results from the Annual Staff Survey and the actions in place to address the key themes outlined in the report.

3. Feedback from external meetings

3.1 In addition to the monthly Healthcare Partners call, I have continued to attend the fortnightly North West regional briefings to all NHS trust chairs. These meetings have proved to be a valuable networking opportunity with other trust chairs from across our region.

4. Changes to the Board - Executive Directors

4.1 As advised in March, assessment centres were held for three executive director roles following the retirement of the Medical Director and Director of Finance, and the resignation of the Chief Operating Officer. I am pleased to advise that the Trust has been successful in the appointment of:

- Lesley Neary as Chief Operating Officer from 1 June 2021
- Dr Kate Clark as Medical Director from 7 June 2021
- John McLuckie to the role of Director of Finance from 1 June 2021

4.2 I am also pleased to announce the appointments of:

- Nina Russell to the role of Director of Transformation. Nina will be starting with the Trust on 6 April.
- Chrisella Morgan to the role of Deputy Chief Operating Officer. Chrisella had been appointed to the role in December on an interim basis.

On behalf of the Board, I would like to extend my thanks too to Steve Christian who leaves the Trust at the end of April following his appointment to the board of Lancashire and South Cumbria NHS Foundation Trust as Chief Integration Officer. As Deputy Chief Executive and Chief Operating Officer, Steve has championed the eradication of corridor care within our Urgent and Emergency Care department which the Trust has achieved for the last 13 months. I would like to say thank you to Steve and wish him the very best of success for the future.

5. Changes to the Board - Non-Executive Directors

5.1 I am pleased to announce that NHSE/I have appointed Pauline Gibson as a substantive non-executive director from 1 May 2021. This was in recognition of the work Pauline has done as Chair or Workforce Committee and as NED Freedom to Speak Up Champion.

5.2 Unfortunately, this is also the last Board meeting for our Non-Executive Director Julie Gorry, who will be leaving her role as NED at the end of April. Julie has been a valued member of the Board who has contributed initially as Chair of Quality and Safety Committee and most recently as the NED champion for the Maternity and co-lead of the Charitable Funds group. On behalf of the Board, I would like to extend my thanks to Julie and wish her the very best for the future.

5.3 The Trust has now formally commenced the recruitment for an Associate Non-Executive Director. I am pleased to confirm that the advert is now live on NHSE/I, Cabinet Office (both below) and Women on Boards websites:

- Non-executive opportunities in the NHS » Southport and Ormskirk Hospital NHS Trust, Associate Non-executive Director (england.nhs.uk)
- Southport and Ormskirk Hospital NHS Trust, Associate Non-executive Director (cabinetoffice.gov.uk)

6. Charitable Funds

6.1 The S&O Charitable Funds Committee is scheduled to meet on April 2021.

6.2 The Board is 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.

Title of Meeting	BOARD OF DIRECTORS	Date	07 April 2021
Agenda Item	TB044/21	FOI Exempt	NO
Report Title	CHIEF EXECUTIVE'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 March. 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:	
☐ 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:
Trish Armstrong-Child, CEO	Trish Armstrong-Child, CEO

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 North West Specialty and Associate Specialist doctors (SAS) Awards

Congratulations to Mr Chetan Sangani, Clinical Director in Trauma and Orthopaedics, who won the top prize in the leadership category of the North West Specialty and Associate Specialist (SAS) Awards organised by Health Education England. His colleague, Mr Karthikeyan Iyengar, was also a winner, taking home the SAS Undergraduate Educator Award.

1.2 HSJ Value Awards 2021

The Paediatric Diabetes team are finalists in two categories of this year's HSJ Value Awards to be held in June:

- Diabetes Care Initiative of the Year category for the project "Person-centred practice finally made real and at scale before, during and after Covid".
- Paediatric Care Initiative of the Year with "Great Oaks from Little Acorns Grow: solution-focused approaches enable flourishing lives after tough beginnings".

1.3 A&E Covid Abstract chosen by Medical Society

Congratulations too to the A&E Therapy Team for having their abstract chosen to be read at the Manchester Medical Society Pan Covid-19 symposium. Moira Burford, Senior Occupational Therapist, presented "Oxygen home-monitoring pathway for suspected and confirmed Covid-19" on behalf of the team.

1.4 Thanks a Bunch and SO Proud Awards

Well done to all the bed managers who were awarded our team award, Thanks a Bunch, for March. SO Proud award for staff who have gone above and beyond this month went to:

- Lauren Jones, Complaints & Governance Officer, Complaints and Governance Team
- Kirsty Bevington, Transformation Lead in the Project Management Office

2 News and Developments

2.1 Covid-19 vaccination programme

Nearly 12,000 staff, local health and social care colleagues, and immediate family members of our staff who met the nationally mandated criteria have received their first dose of vaccine from the Trust since January. We began administering second doses on 22 March.

At 1 April 2021, 85% of all staff had been vaccinated, including 94% of staff shielding and 85% of BAME colleagues. We continue to reach out to those colleagues for whom we have no vaccination record.

On April 1 we also welcomed back colleagues who have been shielding due to Covid-19. We put in place of programme for them and their managers to ensure support was available as they returned to the workplace. Some have been obliged to stay at home since April last year.

2.2 Staff Survey 2020

2020 was a year like no other, so it was more important than ever to hear what work life has been like for you in the annual NHS Staff Survey. Forty-five percent of staff completed the survey (1,412 questionnaires) which was in line with the response rate of 128 similar NHS trusts, and one of the best in the North West.

The results showed overall improvement across all 10 themes of the survey.

- Three themes were **significantly improved** - health and wellbeing, safe environment, and violence and safety culture - suggesting staff are more satisfied with the interest the Trust takes in their safety and wellbeing
- Two themes **exceeded** the national average score - equality, diversity and inclusion, and health and wellbeing
- We **meet the national average** score for morale, quality of care, and safe environment (both bully and harassment, and violence)
- Staff said they were **satisfied** with the quality of care they can give to patients/service users, and 89% said they felt their role made a difference to patients/service users.
- Our staff engagement score (that is, how motivated and engaged staff are at work), happiness with the standard of care provided and whether staff would recommend the Trust as a place to work **improved** but there is still work to do
- Although we have improved in the theme of safety culture overall, perceptions of fair treatment are **below the national average**, showing we must double-down on our commitment to embed a just and learning culture, which is part of our plan in the coming year
- Other areas for improvement include greater engagement with your manager and the need for improved teamwork

3 Trust News

3.1 International Women's Day

We marked International Women's Day (IWD) on 8 March by sharing videos of the thoughts, ideas, and career and life advice from seven women across the Trust.

These included:
- Bridget Lees, Director of Nursing, Midwifery and Therapies
- Jane Royds, Director of HR and Organisational Development
- Pauline Gibson, Associate Non-Executive Director;
- Mel Pinnington, Clinical Educator in Clinical Care
- Rachelle Alty, Head of Professional Practice Development for Nursing and Midwifery
- Dr May Ng, Associate Medical Director for Specialist Services.

I was delighted to take part in a conversation with Estephanie Dunn, Regional Director of the RCN, for IWD about my leadership journey.

3.2 Discharge Volunteering

A volunteering programme to help prevent readmissions following discharge got under way in March. The nationally-funded pilot will run on three wards at Southport hospital: 14A, 14B and 9A.

The volunteers will make calls to patients within 72 hours of discharge and any immediate or urgent issues will be picked up and referred to designated members of staff.

We will also offer a signposting service and are working with Age UK, Sefton CVS and Healthwatch Sefton around hot meal deliveries, short-term hospital aftercare, befriending and the like. If successful, it is hoped this will be rolled out across all wards.

3.3 Covid-19 Anniversary

We released a 20-minute film, “Covid, one year on: a reflection”, on 18 March to mark the anniversary of the first positive Covid result for an inpatient at Southport Hospital.

There were contributions from the Chief Executive, Board Non-Executive Director Gurpreet Singh, and Hospital Chaplain the Rev Martin Abrams. The main part of the reflection, however, is a poem inspired by Michael Rosen’s ‘These Are The Hands’.

He wrote the poem to mark the 60th anniversary of the NHS in 2008. Last year, staff were asked to offer their own lines for a hospital “thought for the day”. Now updated with new contributions, Michael joined staff in a reading of the poem as part of the day’s reflection. He said it was “a pleasure” to contribute to the reading.

4 Reportable Issues Log

Issues occurring between 23/02/2021 and 22/03/2021

4.1 Serious Incidents and Never events

- No Never Events to report.
- One Serious Incident reported which relates to a delay in treatment, this is currently subject to an investigation.

4.2 Level Four and Five Complaints

Two level 4 complaints have been logged during the timescale, both relate to care and treatment. These will be investigated through the Trust’s complaints process.

4.3 Regulation 28 Reports

No regulation 28 reports have been received from the coroner.

5 Media coverage

- *Successful pilot sees refugee nurses supported into NHS workforce (Nursing Times, 12 March 2021)*
- *Michael Rosen joins hospital staff in Covid poetry reading (Champion newspapers, 18 March 2021)*
- *Residents have say on health services (Ormskirk Advertiser, 26 March 2021)*
- *£1k boost for NHS hospitals (Southport Visiter, 26 March 2021)*
- *Angel watches over hospital (Southport Visiter, 26 March 2021)*

6 Risk Register and Board Assurance Framework

Risk registers have been updated and presented at this month's sub committees. No significant changes to note.

Trish Armstrong-Child
Chief Executive
30 March 2021

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB045/21	FOI Exempt	NO
Report Title	INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK		
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) Assurance Framework (AF).

Executive Summary

The IPC BAF was first reported to the Board in July 2020 and has continued to be presented at presented since then. Since the last repor,t an updated document has been published by NHSE/I, some of the key lines of enquiry have been retired and additional measures have been introduced, these are highlighted in **bold.**

New areas include:

- Pathways in place which support minimal or avoid patient bed / ward transfers during admission unless clinically imperative
- Monitoring of patient compliance of the wearing face masks.
- Assurance processes in place for monitoring and sign off of terminal cleans as part of outbreak management
- Staff maintaining social distancing of 2 meters plus when travelling to work (including avoiding car sharing)
- Sites with high nosocomial rates should consider testing covid negative patients daily

The latest version of the IPC BAF shows that we have completed 95 of the 108 areas included in the IPC BAF and that we are progressing on schedule for the other 9. We have systems and processes in place to manage and monitor IPC guidance and identify risks.

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 bi-weekly basis.

Progress

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

- All wards and clinical areas not compliant with the 2m bed spacing have now been fitted with screens with the exception of Ward 15a (due to it being a Covid-19 cohort area). However both wards on the 15 template meet with the 2m bed spacing requirements. This is currently an extreme risk on the risk register and will be downgraded on completion of the roll out plan.
- Roll out of staff Covid-19 Vaccination Programme as of 09 March 2021 10,225 first doses have been administered
- 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.

- The Trust has now trained a Team of Fit Testers to assess staff for non-3M masks as per national PHE guidance. PMO through Silver Command have reviewed the data collection process as of 12.03.2021 2,698 clinical staff have been fitted for masks.

- Additional PPE Donning and Doffing training is now recorded on ESR. **16.03.2021**, a total of **914** staff from a number of disciplines have been recorded as compliant. The IPC Team with work with Training Team to complete a TNA – numbers of staff who need Donning & Doffing training and how many are compliant with training. It is anticipated this will be incorporated into Mandatory Training going forward.

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

1. Hand Hygiene Audits - Trust compliance Feb 2021 **(96.4%)** ↓ above target
2. PPE Compliance Audits - Trust compliance Feb 2021 **(96.6%)** ↓ above target
3. IPC Mandatory Training - Compliance
   a. Level 1 Feb 2021 **(90.97%)** ↓ above target
   b. Level 2 training Feb 2021 **(80.14%)** ↑ below target

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

This framework will be regularly revisited to monitor progress and mitigation regarding gaps and compliance against any new or amended guidance. Updates will continue to be presented to IPC Assurance Group, Quality & Safety Committee and Trust Board.

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

Publications approval reference: 001559

Infection prevention and control board assurance framework

February 12, 2021. V1.6

Updates from V1.5 are highlighted in **bold**

Foreword

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

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

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

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

Ruth May
Chief Nursing Officer for England

1. Introduction

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

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

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

2. Legislative framework

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

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

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

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

Infection Prevention and Control board assurance framework

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
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		
• **there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative**	• 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		
• **that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per**	• We have processes in place to ensure that when a patient is transferred / discharges the area is cleaned and disinfected. • Disinfection includes use of chlorine dioxide solution and in addition UVC light disinfection or hydrogen peroxide vapor. • Cleaning schedules are monitored				

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
guidance.	and reported through the daily sit-rep				
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • **staff adherence to hand hygiene?** • **staff social distancing across the workplace** • **staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: (a) clinical** • **b) non-clinical setting**	• Ward Walking by Quality Matrons and IPC Team • Hand Hygiene Audits (Trust compliance end February 2021 **(96.4%),** this is decrease on last month (100% January 2021) • PPE Compliance Audits for end February 2021 **(96.6%),** this is a slight decrease on last month (98.1% January 2021). • 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 surgical face masks used in the Trust are fluid resistance in clinical and non clinical settings • All corporate staff required to wear face masks at desks in Corporate Management Office (CMO) and in non clinical environments	• Slight decrease in Hand Hygiene and PPE compliance (however still within tolerance)	• The IPC Team are working with the clinical areas who have seen a drop in performance since the previous month to ensure standards are maintained • Communication to all staff regarding the requirement to wear appropriate PPE at all times; any observed breaches of compliance will be actioned in accordance with HR policy.		
• monitoring of compliance with **wearing appropriate PPE, within the clinical setting** • consider implementing the role of PPE	• As above - PPE Compliance Audits for end February 2021 **(96.6%),** this is a slight decrease on last month (98.1% January 2021). • The Trust is utilisng existing teams such as IPC and Quality Matrons to	• Slight decrease in PPE compliance (however still within tolerance)	• The IPC Team are working with the clinical areas who have seen a drop in performance since the previous month to ensure standards are maintained		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
guardians/safety champions to embed and encourage best practice	encourage best practice. We are also using safety huddles and ward meetings to emphasize PPE requirements		• Communication to all staff regarding the requirement to wear appropriate PPE at all times; any observed breaches of compliance will be actioned in accordance with HR policy.		
• **implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace**	• We introduced twice weekly lateral flow antigen testing for NHS patient facing staff since 24.11.20. • Staff are given a supply of lateral flow test kits, results are forwarded to the Lab and positive results are communicated to Staff Health & Wellbeing and are followed up with a PCR Test • Staff test and trace is actioned by Staff Health & Wellbeing • Trust currently rolling out LAMP Testing for clinical staff	• Not all staff are reporting test results through electronic method / smart phones	• Direct communications to staff and reminders in Trust News to highlight the importance of reporting results. • Testing guidance has also been simplified to support staff. • W/C 22.03.21 – all patient facing staff have been transitioned to LAMP testing	New	
• **additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.**	• We would implement if requested to by the regional IPC Team. • In January / February we extended lateral flow testing offer to included non clinical staff due new Covid variant reported in local areas by PHE	None identified	N/A	New	
• training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory	• IPC Mandatory Training - Compliance – Level 1 Feb 21(**90.97%**) – Target achieved and slight decrease on previous month (91.24%). • Level 2 training Feb 2021 **(80.14%)** – below target and a slight increase on previous month (78.72%) • IPC training is covered in Clinical	Not reached 85% target for Level 2 IPC training in February 2021	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 (Feb 21)	New BRAG Rating (March21)
training	Induction which has remained mandatory for all new starters during Covid • Online You Tube training		Ward Walking by Quality Matrons, IPC Team and senior leaders		
• 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 **16.03.2021**, a total of **914** staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. This figure is an improvement from the previous week. 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. ○ The Trust has now trained a Team of Fit Testers to assess staff for non 3M masks as per national PHE guidance. PMO have reviewed the data collection process as of 12.03.2021 2,698 clinical staff have been fitted for masks. • Quality Matrons and the IPC Team to support Ward Walking and promoting PPE compliance • Since June 2020 (when all staff were required to wear face masks) 'wearing face mask correctly' posters has been provided through Trust	Training records in relation to Donning & Doffing training is currently paper based but in process of moving to electronic (ESR)	Despite being slightly below target for Level 2, supplementary training is in place and monthly PPE audits demonstrate high compliance - end February 2021 **(96.6%)** 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 The IPC Team with work with Training Team to complete a TNA – numbers of staff who need Donning & Doffing training and how many are compliant with training. It is anticipated this will be incorporated into Mandatory Training going forward.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	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.				
• **there are visual reminders displayed** communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• 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) • Signage is widely displayed on entrance to the Trust and all departments within the Trust, both clinical and non clinical	None identified	N/A		
• 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	• As above, risks in relation to Covid-19 (PPE, equipment, service moves and staffing). Reviewed by IPC group, Gold command and Clinical	None identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
highlighted	Reference Group (CRG).				
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Yes, Covid-19 related risks reviewed on weekly basis and reported through Gold, ETM, QSC (monthly) and Board (monthly)	None identified	N/A		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Work process in place for non covid infections which is linked into Medway and reported through the IPC epidemiological IT program. • Swabbing and screening processes in place for other infections such as MRSA, CDIFF etc. • Risk assessments in place, all clinical areas are zones into red or green. • Monthly IPC report in place • Quality Priority (including IPC) monthly reports submitted to QSC and Board.	None identified	N/A		
• that Trust CEOs **the Medical Director or the Chief Nurse** approve and personally signs off, all **daily** 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• **This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board**	• Reported through Outbreak meetings to Silver and Gold command structures then to Board • Reported via Quality & Safety Committee. • COVID Updates and Outbreaks reported to Trust Board • In addition the IPC 10 Key Actions Document is reviewed bi-weekly (every two weeks) by Silver and Gold Command	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		
• **there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas**	• Reported through Outbreak meetings to Silver and Gold command structures then to Board • Reported via Quality & Safety Committee. • COVID Updates and Outbreaks reported to Trust Board • In addition the IPC 10 Key Actions Document is reviewed bi-weekly (every two weeks) by Silver and Gold Command y- this gives Execs and Senior Leadership Teams an opportunity to verify	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:					

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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 Feb 21(**90.97%)** – Target achieved and slight decrease on previous month (91.24%). • Level 2 training Feb 2021 **(80.14%)** – below target and a slight increase on previous month (78.72%) • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • You Tube video remains on line and latest guidance available on intranet and in clinical areas. • Ward Walking by Quality Matrons and IPC Team to provide advice and support • Regular Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards	Not reached 85% target for Level 2 IPC training in February 2021	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 Ward Walking by Quality Matrons, IPC Team and senior leaders		
• 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 February 2021, 920 Covid and 185 non Covid Isolation cleans have been undertaken and 616 Enhanced 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	competencies are held centrally.				
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Yes –cleaning schedule in place. IPC team confirmed we use chlorine dioxide above the recommended guidance. • Additional investment in domestic cleaning teams. • Enhanced cleaning teams already in place for high risk areas. • Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x across 24hrs • In February 2021, 920 Covid and 185 non Covid Isolation cleans have been undertaken and 616 Enhanced cleans were carried out.	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.		
• **Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management.**	• Isolations cleans are reported in the daily sit rep for Executives. Daily cleans are also monitored through the 3x daily bed meetings (7 days a week) and through the Facilities reports.	None Identified	N/A	New	
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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		
• frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails should be decontaminated **more than** twice daily and when known to be contaminated with secretions, excretions or body fluids	• Domestic Cleaning schedules have been revised and updated in clinical areas • Wards, bays and side rooms cleaned twice a day with enhanced cleansing for toilets and bathrooms – 5x across 24hrs • New sitrep in place monitoring sign off of cleaning schedules	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a **minimum of** 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, **ideally** 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		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Laundry bagged in calcium alginate bags then wrapped in clear plastic packaging	None Identified	N/A		
• single use items are used where possible and according to Single Use Policy	• Yes, Single Use Policy is included in IPC Manual	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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		
• 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		
• **Monitor adherence environmental decontamination with actions in place to mitigate any identified risk**	• All areas are monitored by Domestic Supervisors, any issues identified are remedied immediately • Process in place when any staff can request additional cleaning 24/7 or through 3x daily bed meetings (7 days a week) and through the Facilities reports.	None Identified	N/A	NEW	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• **Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.**	• Monitoring of cleanliness of Equipment is audited through the IPC Perfect Ward Audit, any issues identified are discussed with local area and resolved immediately •	None Identified	N/A	NEW	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Systems and process are in place to ensure:					
• arrangements around antimicrobial stewardship are maintained	• Daily Intensive Care Unit ward rounds have been maintained as previously, as have weekly C. difficile ward rounds. • NICE gap analyses are all up to date. • Regular monitoring of antimicrobial resistance on the Spinal Injuries Unit is still being maintained, as planned following an outbreak of a Gentamicin-resistant Gram negative organism last year. • The new adult guidelines were approved at the Antimicrobial Stewardship Committee. Comments were invited from the rest of the trust and then approved by the Drugs and Therapeutics Committee. All antimicrobial guidelines are live in Microguide • induction presentations alerting staff to the change. • Daily ITU ward rounds and weekly C.Diff ward rounds have continued • Paediatric guidelines have been updated and are awaiting approval • Antimicrobial stewardship last met 17th February 2021 • Antimicrobial point prevalence and	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	ARK study data has been collected w/c 8th March • Gent Audit and Teic audit have been completed (Carla will know about these and I will ask her to email) • We have an antimicrobial audit on Perfect Ward App to allow information to go straight to ward managers • Regular meetings with Merseycare for Outpatient Parenteral Antimicrobial Therapy ward rounds				
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Yes via AAA (Drugs and Theraputics Committee and IPC Assurance Committee to Quality & Safety Committee)	None Identified	N/A		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion					
Systems and processes are in place to ensure:					
• implementation of national guidance on visiting patients in a care setting	• We are adhering to regional Cheshire & Merseyside guidance in relation to visiting. Exemptions are in place for End of Life patients, birthing partners in maternity. Parents or Carers in paediatrics and partners of women experiencing pregnancy loss	None Identified	N/A		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Risks assessments in place and clinical areas are Zoned as Red, Amber and Green	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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 visibility. • New posters in place around the Trust featuring the Medical Director	None Identified	N/A		
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	• (1) Emergency admissions – patients assessed for symptoms and also swabbed	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	• (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.				
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection as per national guidance	• Reconfiguration of adults and children's ED and Maternity services. Signs are displayed at all entrances. • Additional reconfiguration in other clinical areas in line with surge plan – QIAs completed and in place	None Identified	N/A		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Algorithm in place for assessing low risk, possible and probable patients as they enter ED and outpatient appointments. Patients are then allocated an appropriate pathway	None Identified	N/A		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• face masks are available for all patients **and they are always advised to wear them**	• 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 **(particularly when moving around the ward) 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		
• **Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)**	• This is currently not monitored through the IPC audits, however staff will advise patients to wear a face mask if not wearing one. All inpatients are given information advising them of their actions to maintain their safety during their stay (this includes wearing of PPE and social distancing and cleaning)	A point prevalence walk around by senior nurses was undertaken in January 2021 to review the wearing of face mask by patients – there was mixed compliance	Patient information was reviewed and staff reminded to discuss mask usage with patients IPC Team to review audits to include patient face mask compliance.	New	
• Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Patients are segregated and in addition we have screens for reception staff and volunteers at front door • Where able to Trust is increasing the distance between patient beds on wards and extended space between chairs in waiting areas. • Trust also reviewing the use of screens where social distancing is restricted	Potentially areas where patient social distancing will be less than 2 meters due to the environment 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 needs are identified. Trust has procured isolation		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• **to ensure 2 metre social and physical distancing in all patient care areas.**	•		screens between bed spaces – they are currently being installed across the Trust (both sites) – As of **16.03.21** All wards and clinical areas on both sites not compliant with the 2m bed spacing have now been fitted with screens with the exception of Ward 15a (due to being a Covid co-hort areas), tracks have been installed on 15b and 6 bed spaces have been completed. However both wards on the 15 template meet with the 2m bed spacing requirements	NEW	
• 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 **and contacts traced promptly**	• 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 (Feb 21)	New BRAG Rating (March21)
• **there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document**	• We review patient swabbing on a daily basis and contact wards where patients tests are due.	None Identified	N/A	NEW	
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other **national guidance**,, to ensure their personal safety and working environment is safe	• IPC Mandatory Training - Compliance – Level 1 Feb 21(**90.97%)** – Target achieved and slight decrease on previous month (91.24%). • Level 2 training Feb 2021 **(80.14%)** – below target and a slight increase on previous month (78.72%) • 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 February 2021	Despite being slightly below target for Level 2, supplementary training is in place and monthly PPE audits demonstrate high compliance - end February 2021 **(96.6%)** 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 Ward Walking by Quality Matrons, IPC Team and senior leaders		
• all staff providing patient care **and working within the clinical environment** 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 **16.03.2021**, a total of **914** staff from a number of disciplines have been recorded on ESR as having received training in donning & doffing of PPE. This figure is an improvement from the previous week. 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. ○ The Trust has now trained a	Training records in relation to Donning & Doffing training is currently paper based but in process of moving to electronic (ESR)	Despite being slightly below target for Level 2, supplementary training is in place and monthly PPE audits demonstrate high compliance - end February 2021 **(96.6%)** 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 The IPC Team with work with Training Team to complete a TNA – numbers of staff who need Donning & Doffing training and		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	Team of Fit Testers to assess staff for non 3M masks as per national PHE guidance. PMO have reviewed the data collection process as of 12.03.2021 2,698 clinical staff have been fitted for masks. • You Tube video remains on line and latest guidance available on intranet and in clinical areas • Regular Perfect Ward audits commenced w/c 26.10.20 to monitor PPE compliance and IPC standards across wards		how many are compliant with training. It is anticipated this will be incorporated into Mandatory Training going forward.		
• 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. ○ 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 915 records moved to ESR The IPC Team with work with Training Team to complete a TNA – numbers of staff who need Donning & Doffing training and how many are compliant with training. It is anticipated this will be incorporated into Mandatory Training going forward 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 (Feb 21)	New BRAG Rating (March21)
• adherence to PHE national guidance on the use of PPE is regularly audited **with actions in place to mitigate any identified risk**	• 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 February 2021 **(96.4%),** this is decrease on last month (100% January 2021) • PPE Compliance Audits for end February 2021 **(96.6%),** this is a slight decrease on last month (98.1% January 2021). • 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	• 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				

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• staff maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • **staff maintain social distancing of 2 meters plus when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace.** • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear **visually displayed** advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	are asked to wear face coverings • We have segregation in place to minimise risks to patients and in addition we have screens for reception staff and volunteers. • Where able to Trust is increasing the distance between patient beds on wards and extended space between chairs in waiting areas. • Information in relation to car sharing and social distancing on public transport has been disseminated through Trust News. • Trust also reviewing the use of screens where social distancing is restricted • Posters visible promoting social distancing and wearing of face masks • Signage is widely displayed on entrance to the Trust and all departments within the Trust, both clinical and non clinical				
• 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 January 2021 **(100%),** this is an improvement on last month (99.3% December 2020)	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• All hand dryers have been deactivated and paper towel dispensers and waste bins are in place in all areas	None Identified	N/A		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Wipeable signs and pictorial guides on hand hygiene posted in public and staff toilets	None Identified	N/A		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Yes, this has been communicated to staff through communications.	None Identified	N/A		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Yes, this has been communicated to staff through communications. • SOP including flow chart in place explaining how to contact absence line and swabbing referrals •	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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		
• 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,	• 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	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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
visitors or staff	wards with covid positive or strongly suspected patients primarily on the Southport site. • Staff are assigned individual wards and on the whole are kept within that ward unless there are extenuating circumstances				
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk area	• All wards are locked down and clear signage indicating Covid zone status and PPE requirements	None Identified	N/A		
• 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 **16.03.21** All wards and clinical areas on both sites not compliant with the 2m bed spacing have now been fitted with screens with the exception of Ward 15a (due to being a Covid co-hort areas), tracks have been installed on 15b		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
			and 6 bed spaces have been completed. However both wards on the 15 template meet with the 2m bed spacing requirements		
• 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		
8. Secure adequate access to laboratory support as appropriate					
There are systems and processes in place to ensure:					
• 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 of the testing turnaround times with focus on the time taken	• Audits are undertaken by St Helen's and Knowsley NHS Trust and reported to laboratory contracting group	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
from the patient to time result is available					
• 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		
• 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		
• screening for other potential infections takes place	• Yes, also screen for flu, MRSA, Strep, Legionella	None Identified	N/A		
• **that all emergency patients are tested for COVID-19 on admission**	• Yes, all patient who are identified for admission are covid swabbed	None Identified	N/A	NEW	
• **that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.**	• Yes, any inpatient with symptoms is retested and isolated	None Identified	N/A	NEW	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• **That those emergency admissions who test negative on admission are retested on day 3 of admission and again between 5-7 days post admission**	• Yes, Initial swab taken on admission (either ED, EAU or Pre-op for planned admissions) • 2nd Swab taken on base ward (patients cannot be moved until result returned) • Day 3 swabs now undertaken on all ED admissions who have a negative swab on admission and all elective who have a LOS of >3 days. Day 5 swabs completed when patient arrived at base ward.	None Identified	N/A	NEW	
• **that sites with high nosocomial rates should consider testing COVID negative patients daily.**	• Yes, If an outbreak is detected, we would increase patient testing accordingly and consider daily testing if required.	None Identified	N/A	NEW	
• **that those being discharged to a care home are being tested for COVD-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge**	• Yes – This is monitored by the discharge planning team.	None Identified	N/A	NEW	
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:					

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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 The capital scheme to address the storage has now commenced on both sites, but works are expected to overrun the original completion date of 31st March 2021, by about 4 weeks. Offensive waste (tiger bags) is currently being re introduced across Southport In line with new NHSE/I requirement, but issues with supply of bags and waste cupboards being out of action due to the capital scheme have slowed this process.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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 (Feb 21)	New BRAG Rating (March21)
	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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	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. ○ PMO in final stages of presenting sustainable solution to hand back to CBUs to deliver. SOP alongside strategic placement of the Portacount machine is being finalized. When this is complete FIT Testing will be returned to the CBUs to deliver on an ongoing basis. ○ Still in process of getting Portacount records uploaded to central system – however		the fit. ○ The Trust has now trained a Team of Fit Testers to assess staff for non 3M masks as per national PHE guidance. PMO have reviewed the data collection process as of 12.03.2021 2,698 clinical staff have been fitted for masks.		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	significant numbers have now been tested and fitted to new masks.				
• 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 different model is used	• Due to the changing availability of FFP3 respirators staff are being reassessed for respirators currently available. • Staff are being identified who will use the half face respirators and are being fit tested. • Portacount system now in place and is gold standard for FIT testing. Testing Hoods also still in use.	None Identified	N/A		
• 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	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
	central record				
• 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 skills and experience and in line with nationally agreed algorithm	• To date any member of staff who has failed a fit test has been given access to a powered air purifying respirator (PAPR) or staff are not rostered to work if there isn't a member of staff who has been successfully tested on duty.	None Identified	N/A		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment 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.	None Identified	N/A		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
including Occupational health					
• 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	N/A		
• 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.	Currently reviewing reporting process	Process to be agreed and put in place		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• There is a general principle that staff are not moved between wards unless there is an urgent need due to clinical need (cover wards). In general staff remain where they are allocated	Movement of ward staff to cover shifts (Safe Staffing)	If reallocation required this is advised to occur at the start of shifts to decrease the risk of cross contamination		
• all staff adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	• Yes, corridors, restaurant and CMO have markings, one way system and posters in place. Masks are provided at all entrances and in all areas (offices and clinical)	None Identified	N/A		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• We have identified Covid secure areas and are also staggering staff break / rest times. • Area risk assessments have been undertaken and relevant information regarding status and capacity is displayed to maintain social distancing.	None Identified	N/A		
• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (Feb 21)	New BRAG Rating (March21)
• 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		

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB046/21	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 highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendations

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

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, Katharine Martin	The Executive Management Team

Activity Summary –February 2021

Indicator Name	February 2020	January 2021	February 2021	Trend
Overall Trust A&E attendances	9,559	6,733	6,545	↓
SDGH A&E Attendances	4,455	3,668	3,524	↓
ODGH A&E Attendances	2,290	959	911	↓
SDGH Full Admissions Actual	1,185	1,269	1,345	↑
Stranded Patients AVG	180	151	142	↓
Super Stranded Patients AVG	66	41	34	↓
MOFD Avg Patients Per Day	60	37	41	↓
DTOC Unconfirmed Avg Per Day	7	-	-	
GP Referrals (*Exc. 2WW*)	2,991	1,693	1,494	↓
2 Week Wait Referrals	746	657	723	↓
Elective Admissions	219	91	79	↓
Elective Patients Avg. Per Day	8	3	3	↓

Activity Summary – February 2021

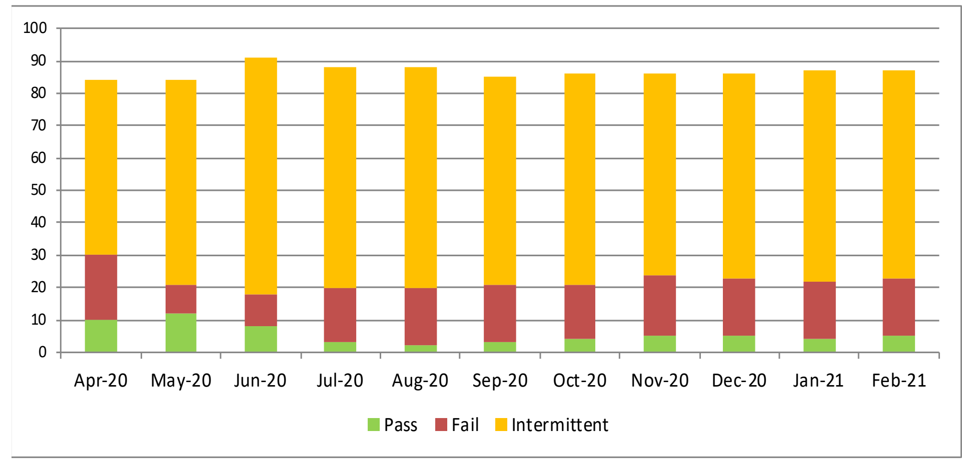
Indicator Name	February 2020	January 2021	February 2021	Trend
Elective Cancellations	19	12	12	▼ (green)
Day case Admissions	1,732	997	1,039	▼ (red)
Day Case Patients Avg. Per Day	60	32	37	▼ (red)
Day Case Cancellations	43	11	9	▼ (green)
Total Cancellations (EL & Day Case)	62	23	21	▼ (green)
Total Cancellations (On or after day of admission, non clinical reasons)	8	1	0	▼ (green)
Outpatients Seen	21,587	18,570	18,938	▼ (red)
Outpatients Avg. Per Day	744	599	676	▼ (red)
Outpatients Cancellations	4,087	3,724	3,825	▼ (green)
Theatre Cases	589	244	238	▼ (red)
General & Acute Beds Avg. Per Day	462	434	421	▼ (green)
Escalation Beds Avg. Per Day	18	5	3	▼ (green)
In Hospital Deaths	73	110	83	▲ (red)

Trust Board - Integrated Performance Report

Head of Information Summary

There is one additional indicator which is now compliant in the IPR, CHPPD in the Quality – Harm Free section is now assured following several months with improving performance. This joins WHO Checklist, Sepsis – timely Identification, HSMR in Mortality and Mandatory Training in Workforce.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Pass	10	12	8	3	2	3	4	5	5	4	5
Fail	20	9	10	17	18	18	17	19	18	18	18
Intermittent	54	63	73	68	68	64	65	62	63	65	64



The overall position is similar to previous months, with the majority of indicators showing intermittent performance (64).

In the past month the Executive leads have reviewed their respective portfolio of indicators, introducing new measures where necessary and altering targets and plans accordingly to ensure they are relevant and achievable for 2021/22.

In the Harm Free section of Quality this month there are three assured indicators, in addition Never Events are showing positive variation with the last incident in May 2019. All indicators in Infection Control are intermittent, and recent variation is not statistically significant, both C-Diff and E.Coli have shown reductions in the past 2 months from relatively high numbers in December. In Maternity the induction rate is not assured, however recent variation indicates performance is improving. The number of occasions 1:1 care not provided is also showing positive performance of late. All other indicators are intermittent in assurance and variance is not statistically significant. In the Mortality section HSMR is assured. Both the SHMI and percentage of deaths screened have negative variation in recent months, with the percentage of deaths screened also not assured as poor performance has been ongoing for many months. The last section in Quality is Patient Experience, only 1 indicator is not assured – DSSA breaches, however recent performance is positive. Complaints turnaround time, and both Duty of Candour metrics are also showing recent improvements.

In the Access section of Operations the 4 hour compliance and 30-60 minute handover times are not assured, the ambulance handover times are improving of late though along with the 60 minute handover times. Metrics relating to RTT waiting times are still effected by Covid so are showing negative variation, additional action plans have been included for RTT, Stroke and TIA. In the Cancer section all metrics are intermittent in assurance, with 14 day referral to outpatients showing recent negative performance. A supplementary action plan has been provided to give assurance on this measure. Under Productivity, bed occupancy at Ormskirk and theatre utilisation at both sites are not

assured so additional action plans have been provided to provide assurance of these measures. Southport bed occupancy and metrics relating to long stay patients should be noted for their improving positions this month.

In the Finance section this month the % Agency staff (cost) and Distance from Agency spend cap remain not assured, however only the three metrics related to run rate are showing negative variation of late with all other metrics improving.

Finally, in the Workforce section the Expenditure on bank/agency staff is not assured and performance is declining. Under Organisation Development the Mandatory training is assured but PDR's are not assured with recent performance not showing any significant signs of improvement. In the Sickness, Vacancy and Turnover section the rolling turnover and sickness rates are not assured, as are the vacancy rates for medics and nurses. The nursing sickness rate and non Covid sickness rates are also not assured. The only indicator showing improvement in this section in the Medical vacancy rate.

Integrated Performance Report

Board Report

February 2021

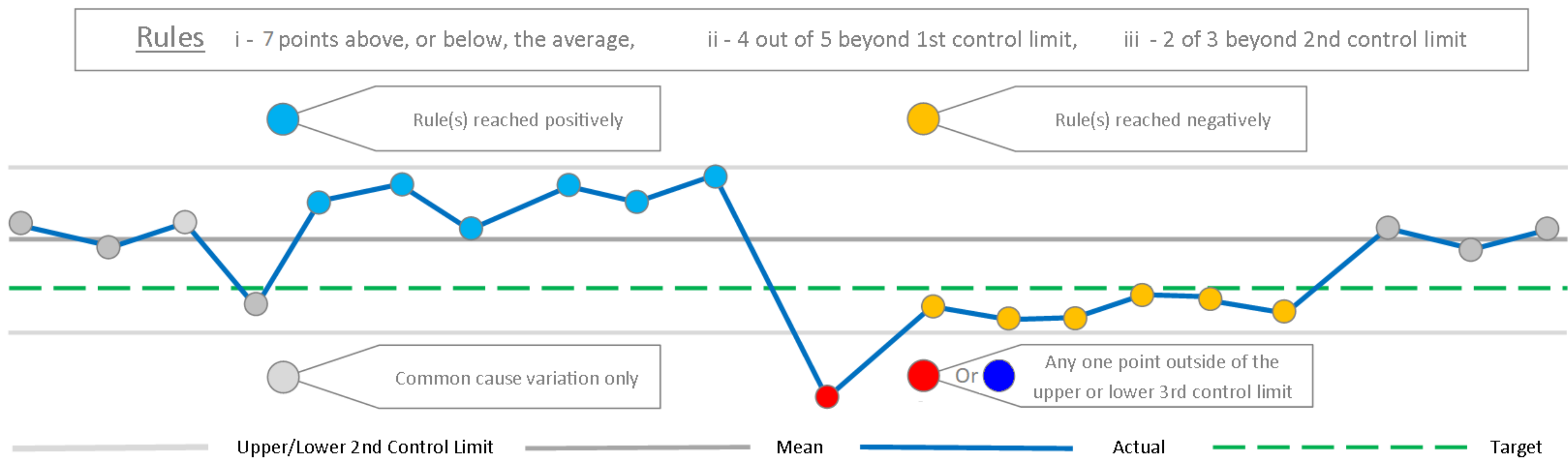
Guide to Statistical Process Control

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

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

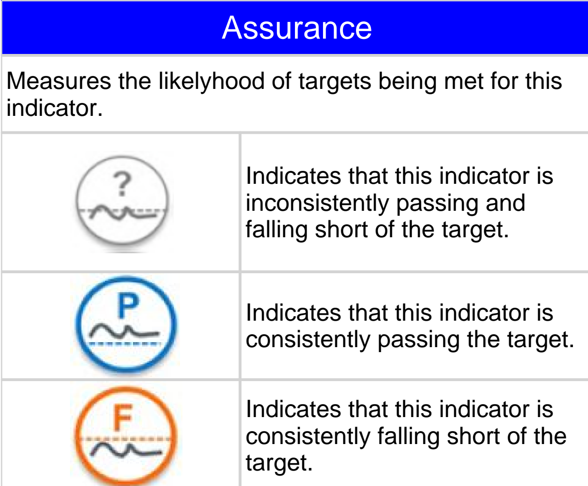
The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line (**dark grey**) is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to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

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



Executive Summary

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Harm Free	0	3	10	0	0	3	1	9
	Infection Prevention and Control	0	0	4	0	0	0	0	4
	Maternity	1	0	8	0	0	0	2	7
	Mortality	1	0	2	0	1	0	0	2
	Patient Experience	1	0	6	0	0	2	2	3
Operations	Access	2	0	11	5	2	0	3	3
	Cancer	0	0	3	0	1	0	0	2
	Productivity	3	0	7	2	1	0	4	3
Finance	Finance	2	0	8	3	0	4	3	0
Workforce	Agency	1	0	0	1	0	0	0	0
	Organisational Development	1	1	1	0	0	0	0	3
	Sickness, Vacancy and Turnover	6	0	5	4	0	0	1	6



Assurance

Measures the likelihood of targets being met for this indicator.

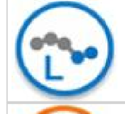
?	Indicates that this indicator is inconsistently passing and falling short of the target.
P	Indicates that this indicator is consistently passing the target.
F	Indicates that this indicator is consistently falling short of the target.

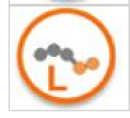
Variation (Past 3 Months)

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

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

Indicates that there is positive variation recently for this indicator.





Indicates that there is negative variation recently for this indicator.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**29 MARCH 2021**
LEAD:	**DR DAVID BRICKNELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- No Alerts this month.

ADVISE

- Although aspects of Fragile Services remain an extreme risk, mitigating actions have been taken to provide support to patients in Head and Neck and Ophthalmics, and new, longer-term, System based solutions for Haematology in collaboration with St Helens look promising.
- Lost to follow up investigations are now back on track and a clearer system of reporting will be put in place, although there are no new concerns to be reported at present.
- A renewed focus on discharge will be reviewed by FPI and Q&S, but the latter will concentrate on the safety of the discharge process and the experience of the patient and their family.
- The IPC BAF recommendations require regular reporting to the Board in relation to, for example, nosocomial infections. Although the Board is informed via the SitRep, a routine format will be devised.
- There is a need to review all the case notes of those whose primary cause of death was Covid-19 which had been acquired within hospital. The factual investigations should take place while memories are fresh, but no conclusions should be drawn until national or regional guidance is clear.
- The Ward Dashboard is already a powerful tool, but the number of audits contained within it are being reviewed following consultation with staff. The report to the Committee will now address concerns and their remediation to provide greater assurance to the Committee and Board.
- There has been a significant decline in mortality review over the last few months, in part because of the lack of guidance for Covid-19 related deaths and in part because of availability of reviewers and distanced accommodation for them. The process is now recommencing in its normal form and will be enhanced by the appointment of the Medical Examiner and their team in the near future.

ASSURE

- In the face of press reports claiming that some Covid-19 patients had received restricted treatment because of lack of resource, the Committee was assured that no patient of this hospital had failed to receive treatment based on their clinical needs, and treatment was not limited on the basis of resource.
- The Committee noted with great pleasure that the Hospital had been advised by the CCG that we were no longer subject to special surveillance in the light of the continued improvement in performance on key measures.

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

Quality

Harm Free

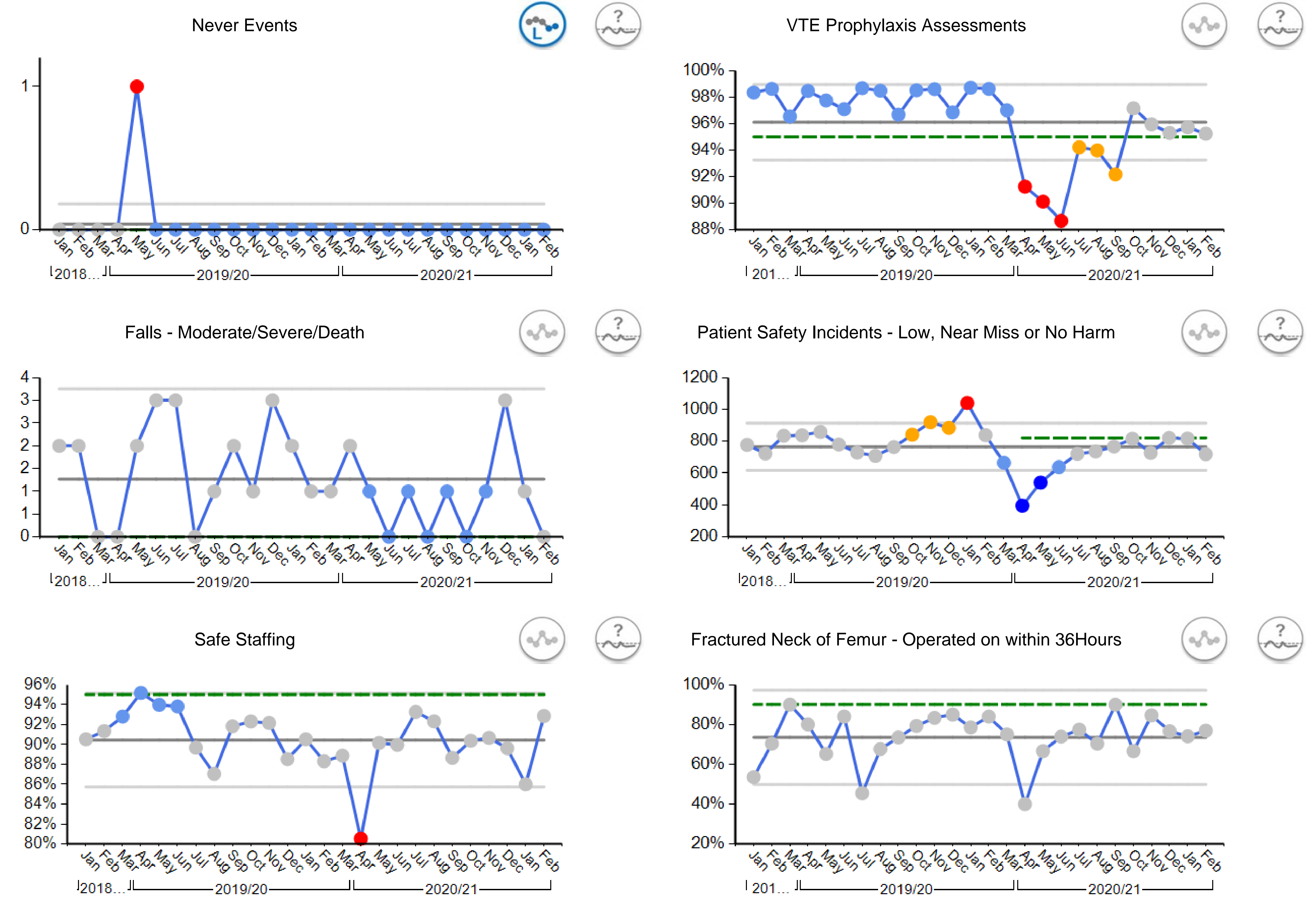
Analyst Narrative:

No indicators within this section are currently failing in their assurance, and three are now assured, which is one more than last month as Care Hours per Patient Day (CHPPD) is now assured. WHO Checklist and Sepsis – Timely Identification are also assured. Encouragingly, there are no indicators showing recent negative variation, whilst four indicators are showing recent positive variation; Care Hours per Patient Day (CHPPD), Never Events, WHO Checklist and Sepsis – Timely Identification.

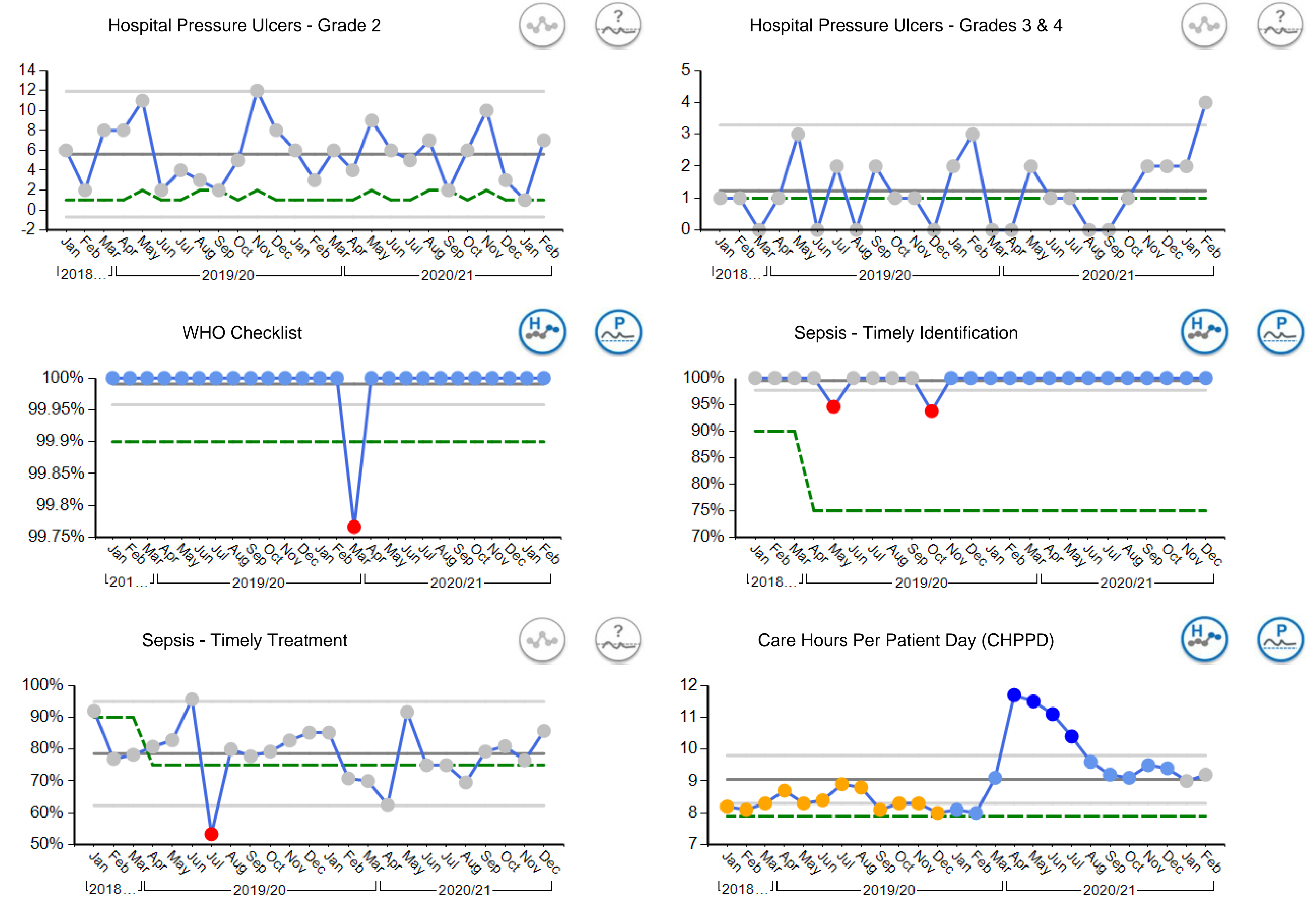
Operational Narrative:

All category 3 and all but two category 2 pressure ulcers have been reviewed at Harm Free Care Panel with two awaiting presentation. In four cases, there were no identified lapses. In five of these investigations there were some identified lapses which included delays/gaps in skin checks and skin bundles being completed.
Of all the category 2 and 3 incidents investigated, some lapses in care have been identified and appropriate action plans are now in place. In addition, Band 7 and Band 6 Nursing staff are being enrolled on to an on line Training session, recommended by the Tissue Viability Specialist Nurse. This is to allow for more timely and accurate grading of tissue damage, especially out of hours.
The 90% safe staffing has been achieved in month. Fluctuations in bed occupancy remains in focused areas as a response to covid activity and we continue to trigger escalation plans to support safe staffing requirements inclusive of staff re-deployment and utilisation of flexible workforce. Staffing continues to be affected by short and long term sickness but with an improving trajectory. International recruitment has remained on trajectory throughout the pandemic with registrants starting to progress into trust substantive numbers.

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
Never Events	0	0	0	Feb 21	L	0	0	Jan 21	0	0	?
VTE Prophylaxis Assessments	95%	95.2%	141	Feb 21		95%	95.7%	Jan 21	95%	93.8%	?
Falls - Moderate/Severe/Death	0	0	0	Feb 21		0	1	Jan 21	0	10	?
Patient Safety Incidents - Low, Near Miss or No Harm	822	719	719	Feb 21		822	817	Jan 21	822	7699	?
Safe Staffing	95%	92.9%	N/A	Feb 21		95%	86%	Jan 21	95%	89.5%	?
Fractured Neck of Femur - Operated on within 36Hours	90%	76.9%	20	Feb 21		90%	74.1%	Jan 21	90%	73%	?
Hospital Pressure Ulcers - Grade 2	1	7	N/A	Feb 21		1	1	Jan 21	18	60	?
Hospital Pressure Ulcers - Grades 3 & 4	1	4	4	Feb 21		1	2	Jan 21	1	15	?
WHO Checklist	99.9%	100%	0	Feb 21	H	99.9%	100%	Jan 21	99.9%	100%	P
Sepsis - Timely Identification	75%	100%	N/A	Dec 20	H	75%	100%	Nov 20	75%	100%	P
Sepsis - Timely Treatment	75%	85.7%	N/A	Dec 20		75%	76.5%	Nov 20	75%	78.2%	?
Care Hours Per Patient Day (CHPPD)	7.9	9.2	N/A	Feb 21	H	7.9	9	Jan 21	7.9	10	P

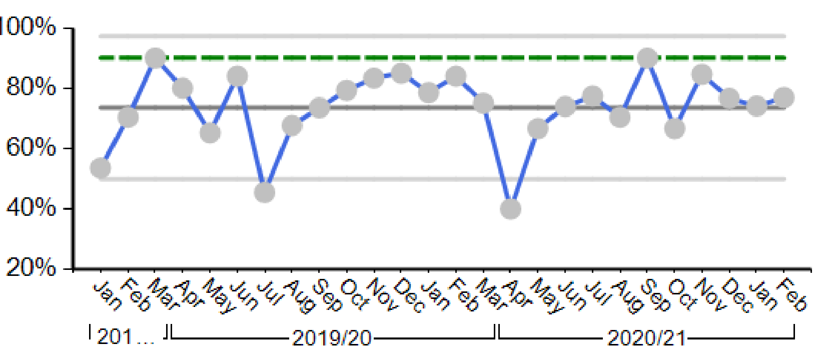


Never Events
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018... 2019/20 2020/21
VTE Prophylaxis Assessments
100%
98%
96%
94%
92%
90%
88%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201... 2019/20 2020/21
Falls - Moderate/Severe/Death
4
3
3
2
2
1
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018... 2019/20 2020/21
Patient Safety Incidents - Low, Near Miss or No Harm
1200
1000
800
600
400
200
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018... 2019/20 2020/21
Safe Staffing
96%
94%
92%
90%
88%
86%
84%
82%
80%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018... 2019/20 2020/21
Fractured Neck of Femur - Operated on within 36Hours
100%
80%
60%
40%
20%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201... 2019/20 2020/21



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)
2018...
2019/20
2020/21

Fractured Neck of Femur - Operated on within 36Hours

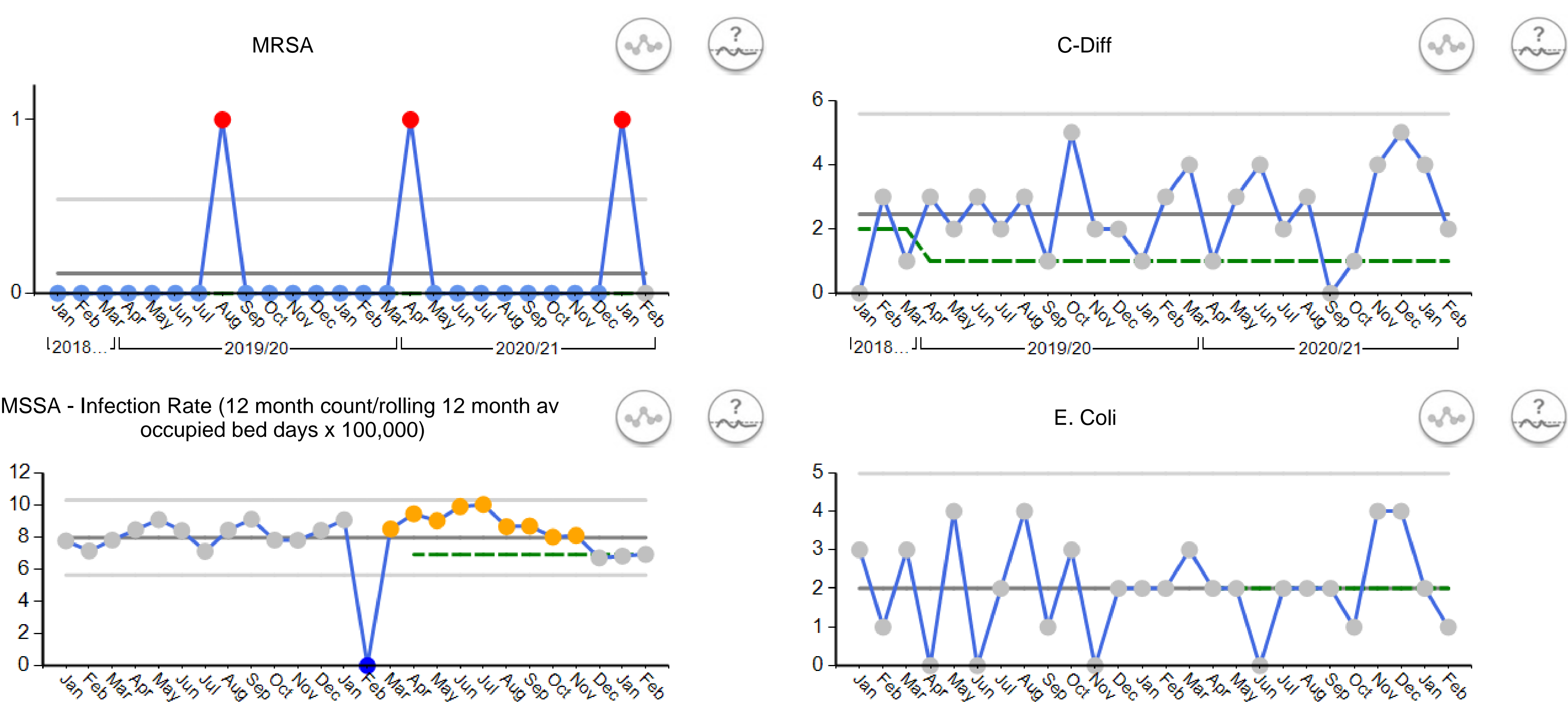


Quality

Infection Prevention and Control

Analyst Narrative: No indicators within this section are assured due to intermittent performance. Additionally, no indicators are showing significant variation. The number of c.diff and e. coli infections has declined to their lowest level since October 2020.
Operational Narrative: MSSA -1 hospital acquired MSSA this month from ITU; the source of the bacteraemia was ventilator associated pneumonia – no lapses identified.
C diff - There were 2 C diff cases attributed to the Trust in February. The 1st case was a Community occurring Healthcare Associated infection. The patient was appropriately treated as an in-patient and there were no lapses. The 2nd case was as Hospital Occurring Healthcare Associated case that developed symptoms and tested positive following admission to hospital. This patient had a complex medical history and was treated with antimicrobials on admission; further antimicrobials were prescribed following admission due to other infections that developed. In reviewing this patient there were some possible lapses which will be further reviewed by the CBUs clinical team.
E coli - Out of the 12 positive E coli blood stream infections identified in February just 1 was considered to be hospital acquired. This case was identified as in excess of 48 hours post admission. The source of this infection was likely to be gastrointestinal, hence even though the patient was appropriately treated on admission for their medical condition their symptoms worsened and became bacteraemic. The patient was successfully treated for their bacteraemia and was discharged.
MRSA - Zero MRSA bacteraemia reported in February
Klebsiella - 3 Klebsiella cases to report in February; One of these cases was an ITU patient that had a dual Klebsiella and MSSA bacteraemia (as reported above under MSSA), was on a ventilator, hence the source of this infection was ventilator associated pneumonia, however the cause was the severe COVID infection. The 2nd Klebsiella case was a patient who required a urinary catheter due to retention; the source of the bacteraemia was catheter associated urinary tract infection. The 3rd case was a patient who required a urinary catheter due to retention; the source of the bacteraemia was catheter associated urinary tract infection. All three of the Klebsiella cases required devices due to their clinical conditions; in reviewing these cases there were no apparent lapses.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
MRSA	0	0	0	Feb 21		0	1	Jan 21	0	2	?
C-Diff	1	2	2	Feb 21		1	4	Jan 21	15	29	?
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	6.9	N/A	Feb 21		6.9	6.8	Jan 21			?
E. Coli	2	1	1	Feb 21		2	2	Jan 21	2	22	?


MRSA
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
C-Diff
6
4
2
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)
12
10
8
6
4
2
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
E. Coli
5
4
3
2
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21

Quality

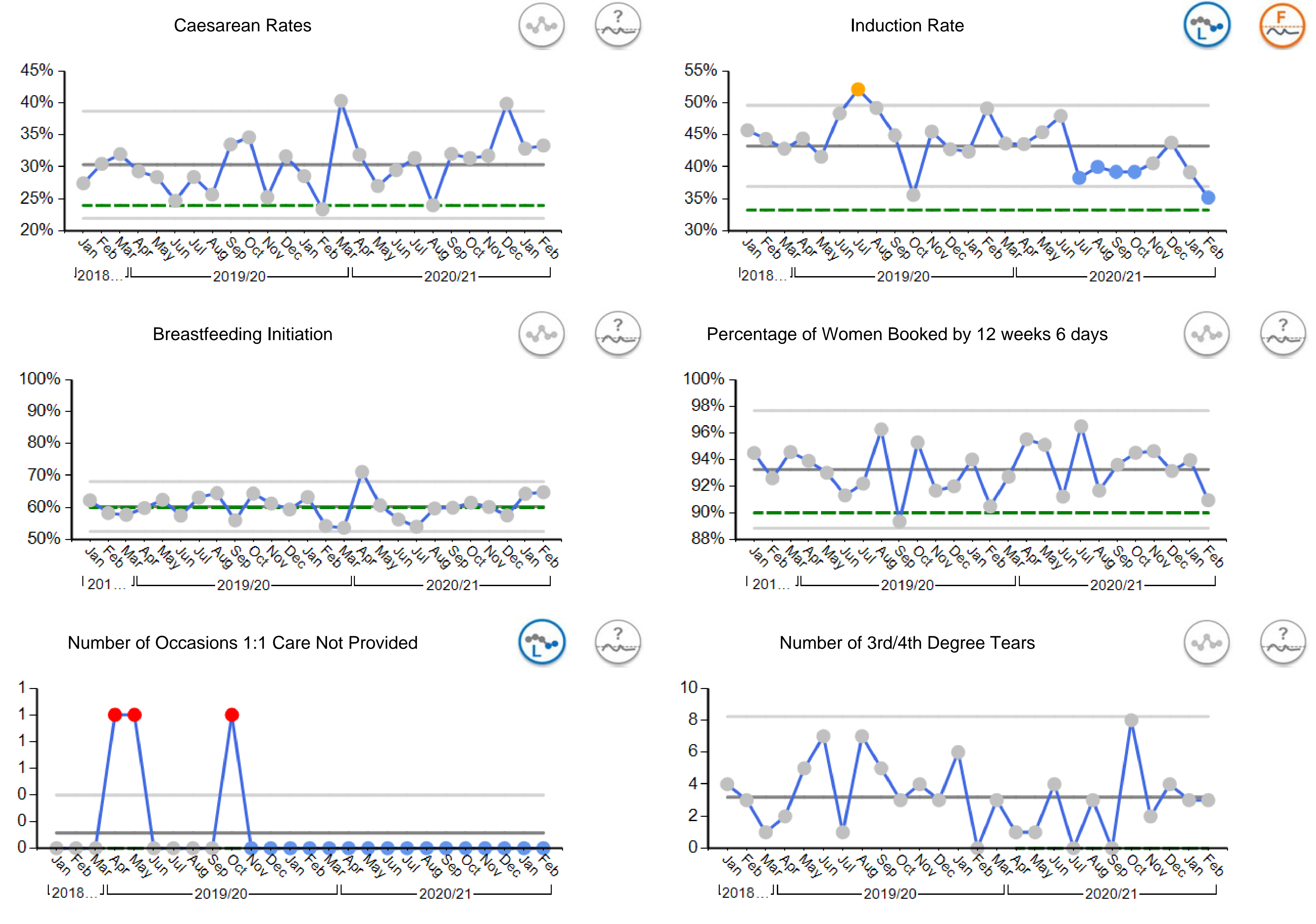
Maternity

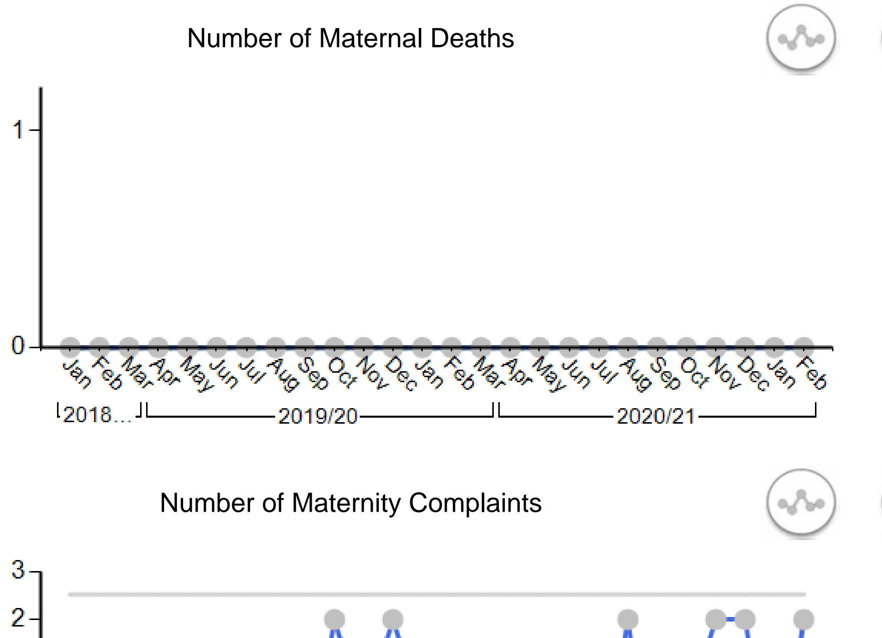
Analyst Narrative: The induction rate is the only indicator failing to provide assurance. This indicator has consistently not achieved plan but there has been a significant reduction in February, with performance well below the mean. This is a despite a marginal increase in caesarean section rates in month. All other indicators within this section remain intermittent in their performance.

Operational Narrative: Induction of Labour continues to be a challenge with the Unit historically having high rates. The national guidelines have changed to support the NHS Safety Agenda and the rates have risen even more, however the Trust continues to be an outlier. Poor foetal outcomes and stillbirths are associated with reduced foetal movements and growth. This has led to increase in induction of labour and caesarean sections. Evidence from previous audits suggests that up to 50% of inductions have been due to reduced foetal movements and slow growth. The current measure for this area has been reviewed and will be adjusted in April in line with regional and national average; this will have a positive impact on the current position.

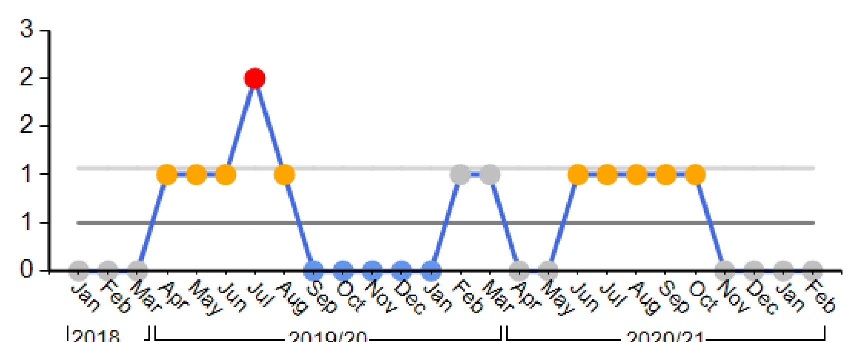
The Trust has been congratulated by the National Perinatal Institute for being in the top 10 in the UK for detection of SGA (Small for Gestational Age) babies for the periods April-June 2020 and October- December 2020.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Caesarean Rates	24%	33.3%	53	Feb 21		24%	32.9%	Jan 21	24%	31.2%	?
Induction Rate	33.3%	35.2%	56	Feb 21	L	33.3%	39.2%	Jan 21	33.3%	41.2%	F
Breastfeeding Initiation	60%	64.8%	56	Feb 21		60%	64.3%	Jan 21	60%	60.8%	?
Percentage of Women Booked by 12 weeks 6 days	90%	91%	19	Feb 21		90%	94%	Jan 21	90%	93.7%	?
Number of Occasions 1:1 Care Not Provided	0	0	0	Feb 21	L	0	0	Jan 21	0	0	?
Number of 3rd/4th Degree Tears	0	3	3	Feb 21		0	3	Jan 21	0	29	?
Number of Maternal Deaths	0	0	0	Feb 21		0	0	Jan 21	0	0	?
Number of Stillbirths		0	0	Feb 21			0	Jan 21		5	?
Number of Maternity Complaints	0	2	2	Feb 21		0	0	Jan 21	0	9	?


Caesarean Rates
45%
40%
35%
30%
25%
20%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Induction Rate
55%
50%
45%
40%
35%
30%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Breastfeeding Initiation
100%
90%
80%
70%
60%
50%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2019/20
2020/21
Percentage of Women Booked by 12 weeks 6 days
100%
98%
96%
94%
92%
90%
88%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2019/20
2020/21
Number of Occasions 1:1 Care Not Provided
1
1
1
1
0
0
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Number of 3rd/4th Degree Tears
10
8
6
4
2
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21



Number of Maternal Deaths
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Number of Maternity Complaints
3
2
2
1
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21



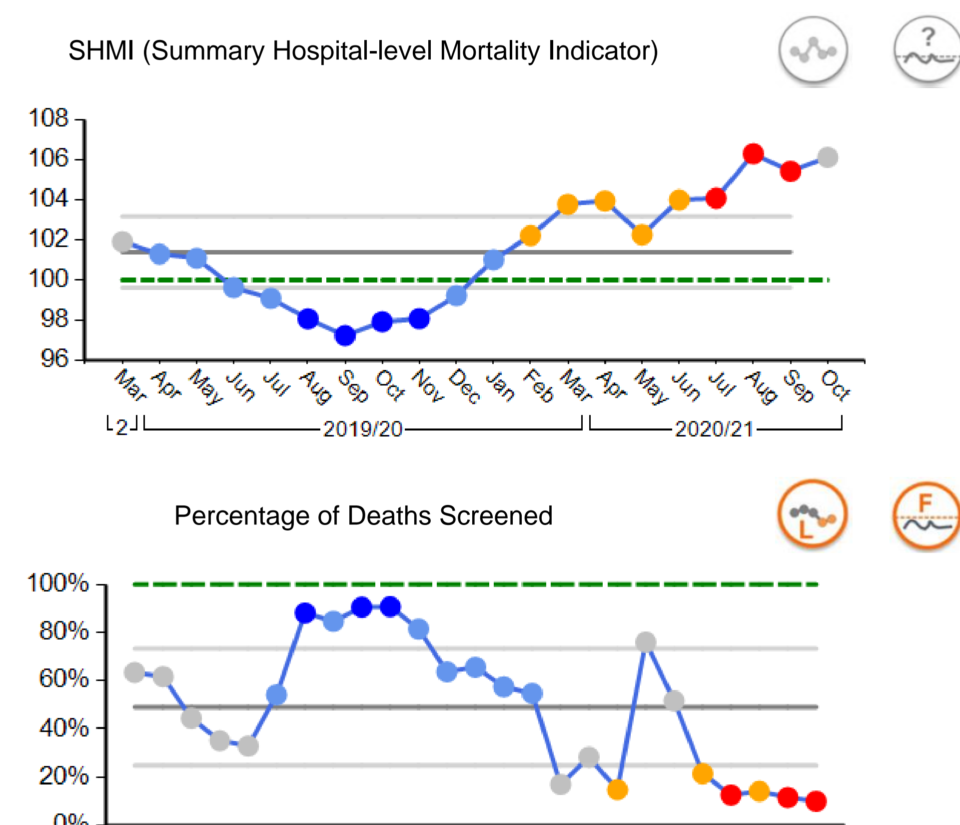
Number of Stillbirths
3
2
2
1
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21

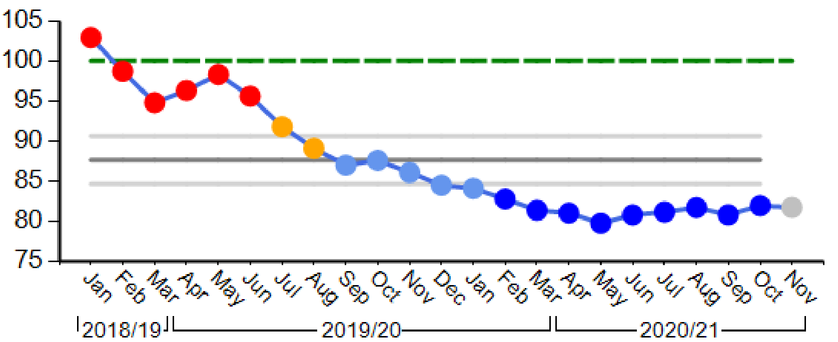
Quality

Mortality

The latest SHMI, for the 12 month period ending September 2020 is 105.41 which is a marginal improvement on the previous month and will now incorporate 6 months of Covid related omissions. Covid will continue to be a factor in mortality reporting for a long time to come as it continues to be a factor in Trust emergency admissions and mortality. The HSMR continues to perform well and is assured.
By exception, the Mortality Screening performance was 10% in January, continuing the poor performance seen since the start of Covid. This will increase when the Medical Examiner's Officer commences in post.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	106.1	N/A	Oct 20		100	105.4	Sep 20	100	104.6	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	81.7	N/A	Nov 20		100	82	Oct 20	100	81.7	?
Percentage of Deaths Screened	100%	10%	99	Jan 21	L	100%	11.6%	Dec 20	100%	22.1%	F


SHMI (Summary Hospital-level Mortality Indicator)
108
106
104
102
100
98
96
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2
2019/20
2020/21
Percentage of Deaths Screened
100%
80%
60%
40%
20%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2018...
2019/20
2020/21


HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)
105
100
95
90
85
80
75
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov
2018/19
2019/20
2020/21

Quality

Patient Experience

Analyst Narrative:

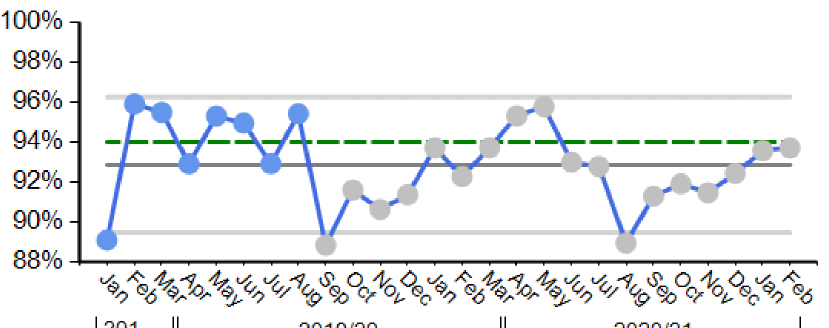
Delivering Same Sex Accommodation continues to fail its assurance measure, but is now showing positive variation, with a second consecutive month of no reported breaches.
The Complaints Average Turnaround time is showing recent positive variation with performance in February less than half that of the previous month. This needs to be sustained for this indicator to be assured. Both Duty of Candour indicators are showing positive variation with no reported breaches since July 2020.
The national Staff Friends and Family Test remains suspended due to Covid, however the indicator was captured within the Staff Survey from Q3 2020/21. Performance on this indicator showed a marked decline from the position reported in March 2020

Operational Narrative

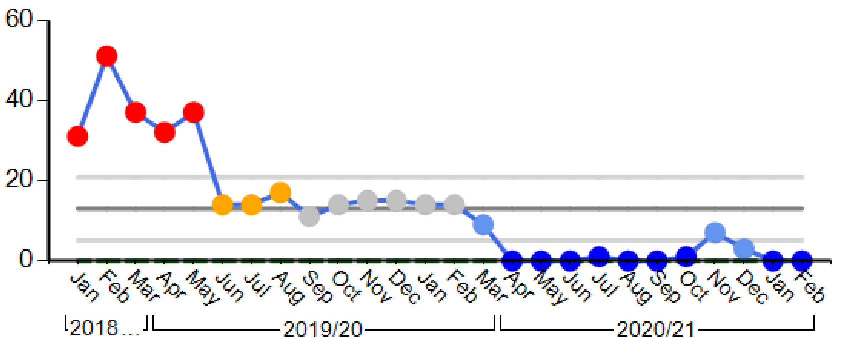
The Trust overall response rate has increased to 25.16% from 24.08%. Those that rated the service as 'Very Good or Good' has increased to 93.71% from 93.57%. The Patient and Community Engagement Group (PECE) have restarted the meetings, reviewed membership, updated terms of reference and priorities for the coming months, including the 'Patient Experience and Community Engagement Strategy' agreed by Trust Board in 2020. The group has representation from patients, Healthwatch, the CBUs and facilities colleagues amongst others. The FFT data will be presented monthly at the forum going forward to generate areas of conversation and focus to improve the experience of our service users.
The overall response rate for Planned Care CBU is 32.9%. Those that rated the service as 'Very Good or Good' has increased to 95.63% from 93.7%. Medicine and Emergency Services overall response rate has decreased slightly to 25.27% from 25.45%. Those that rated the service as 'Very Good or Good' has increased to 93.37% from 92.98. There is a real focus for improvement in these areas around the experience of discharge. The Ward Managers have done thematic reviews regarding good practice and areas of learning. A comprehensive action plan is being developed and managed via the PMO. Adult A&E at Southport response rate has increased slightly to 28.82% from 28.48%. Those that rated the service as 'Very Good or Good' is static at 94.6.
The overall response rate from Specialist Services has increased to 19.27% from 14.82%. Those that rated the service as 'Very Good or Good' is 92.68%. The Maternity Voices Partnership (MVP) is an established forum with an independent chair. The MVP chair will now be a member of PECE as well as the Maternity Improvement Board. Paediatrics overall response rate has increased slightly to 17.46% from 17.07% (Children's Ward 10.19% and A&E 19.18%). Those that rated the service as 'Very Good or Good' is 93.71%. Children's A&E at Ormskirk response rate has increased to 19.18% from 18.2%. Those that rated the service as 'Very Good or Good' is 94.49%. The Paediatric team are looking at setting up a forum for children, young people and their families. The Neonatal team are committed to family centred care and have applied to be a 'Baby Friendly'; we await a response from Unicef.
The Deputy Director of Nursing, Midwifery and AHPs is planning a conference with a focus on Patient Experience in June 2021. This will be an opportunity to show case some of the Quality Improvement (QI) work streams led by the PECE forum.
79% of all complaints closed in February were done so within the target 40 day timescale. This is the highest percentage since July 2020.
The Staff Survey had a response rate of 45% which was in line with the sector average. Our happiness with the standard of care provided should a friend/relative need treatment is significantly less (15.9%) than the average for similar organisations. However, 2020 has not been "business as usual" for the workforce and the impact of the COVID-19 pandemic has had a profound impact across the NHS. The survey showed that staff are satisfied with the quality of care they give to patients/service users (this has improved consistently over the past three years) and 89% of staff felt that their role made a difference to patients/service users (this is consistent with the national average). The Trust has embarked on a change journey but it may take a couple of years before improvements become apparent in the survey results. Further detail is included in the Organisational Development section of this report.

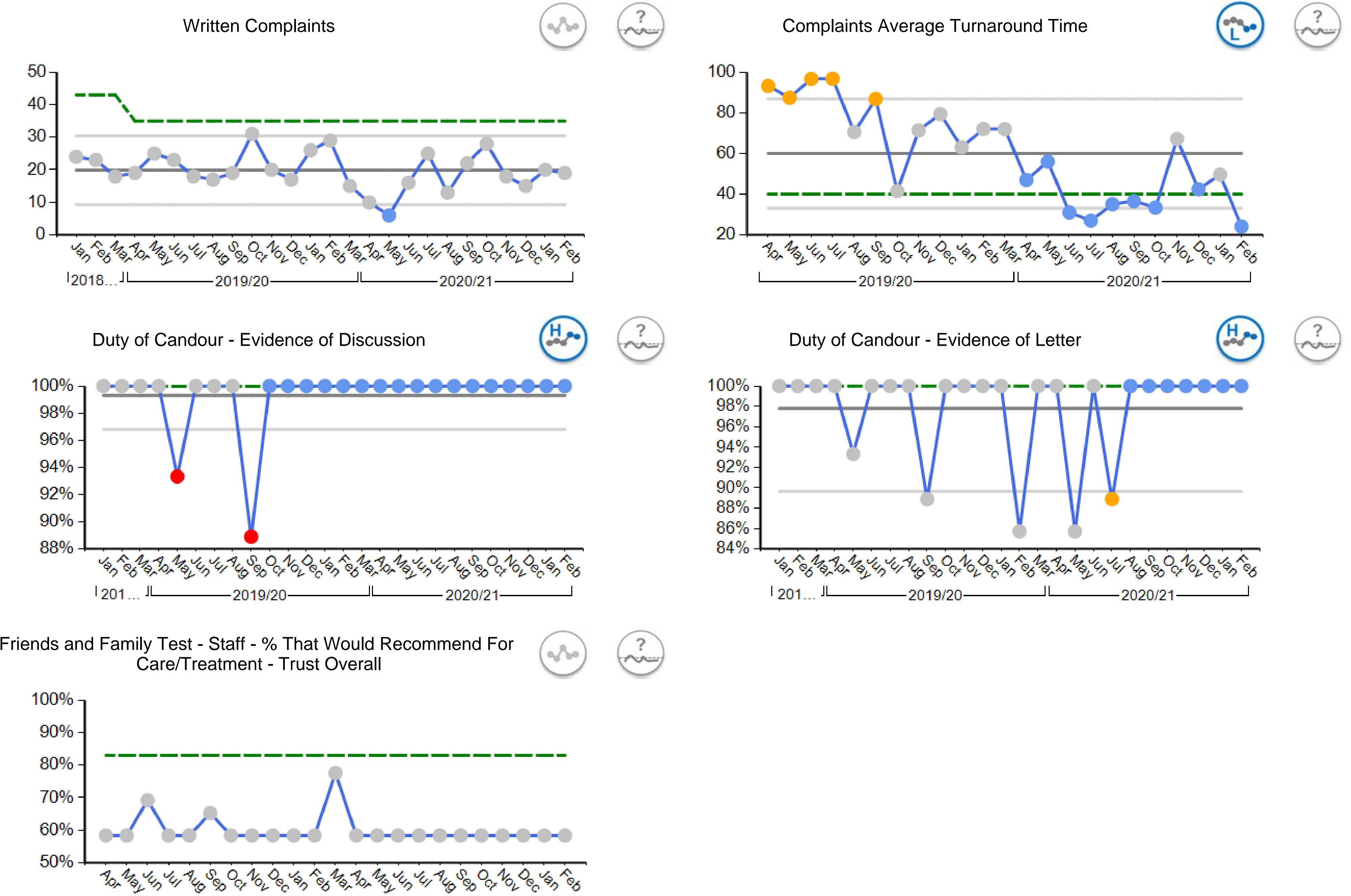
Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	93.7%	79	Feb 21		94%	93.6%	Jan 21	94%	92.4%	?
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	0	0	Feb 21	L	0	0	Jan 21	0	12	F
Written Complaints	35	19	19	Feb 21		35	20	Jan 21	537	192	?
Complaints Average Turnaround Time	40	24.1	N/A	Feb 21	L	40	49.6	Jan 21	40	40.9	?
Duty of Candour - Evidence of Discussion	100%	100%	0	Feb 21	H	100%	100%	Jan 21	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Feb 21	H	100%	100%	Jan 21	100%	97.1%	?
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall	83%	58.4%	N/A	Dec 20		83%	77.6%	Mar 20	83%	58.4%	?

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



DSSA (Delivering Same Sex Accommodation) Breaches - Trust




Written Complaints
50
40
30
20
10
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Complaints Average Turnaround Time
100
80
60
40
20
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21
Duty of Candour - Evidence of Discussion
100%
98%
96%
94%
92%
90%
88%
201...
2019/20
2020/21
Duty of Candour - Evidence of Letter
100%
98%
96%
94%
92%
90%
88%
86%
84%
201...
2019/20
2020/21
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall
100%
90%
80%
70%
60%
50%
2019/20
2020/21

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB048/21	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, the unannounced inspection and other engagement with CQC.

Executive Summary

Progress continues to be made in relation to the improvement plan, the last Quality Assurance Panel (QAP) met on 25 February 2021 to review progress in January 2021. Fifty-three Must and Should do actions have been closed and there are currently 6 Amber and sixty-four Green actions being progressed but not yet ready for sign off.

We have reviewed our 'check and challenge' process to ensure we monitor any actions we have closed are still compliant. Starting in April 2021 a series of 'Go See' visits and 'mock CQC inspections' have been scheduled. Multi-disciplinary Teams comprising of nursing, therapies, medical and administration staff will be trained and will review wards, clinical areas and core services to ensure any improvements are embedded and sustained and to prepare for any forthcoming inspections - this will include a strong focus on well led.

The report also provides a summary of the unannounced responsive inspection of Medicine Core Services by the CQC on 03 March 2021. Initial verbal and subsequent written feedback was positive particularly in relation to the standards of nursing care they observed and the Inspectors commented they found the Urgent Care CBU triumvirate a 'strong team' despite them only being together a relatively short time.

There were some small individual queries on the day of the inspection which we have subsequently responded to and over 22 data requests following the inspection, and these have all been submitted to CQC as requested.

The CQC will publish an inspection report in relation to their visit, no timescales have been established yet, however this report is unlikely to result in a change to any of our CQC ratings published following the 2019 inspection.

For information a summary of progress in relation to the Use of Resources Action Plan can also be founds at section 5 of this report, the Finance, Performance and Investment (FP&I) committee oversee the progress of this action plan. There have been no further updates since this was last reported to Board in February 2021.

Recommendations	
The Board of Directors is asked to **note** the current position against the CQC Improvement Plan, future reporting arrangements and initial feedback in relation to the recent unannounced responsive inspection of Medicine Core Service.	
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:**
Jo Simpson	Bridget Lees

Care Quality Commission (CQC) Update – March 2021

1. PURPOSE OF REPORT

The Care Quality Commission (CQC) carried out an inspection at the Trust between 10 July 2019 and 01 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 provides a summary of the unannounced responsive inspection of Medicine Core Services by the CQC on 03 March 2021.

2. PROGRESS TO DATE

Progress continues to be made in relation to the improvement plan in January 2021. The last Quality Assurance Panel (QAP) met on 25th February 2021 to review progress from January 2021.

As stated in the Board Assurance Framework (BAF) the aim was to complete the CQC Must and Should Do actions by the end of January 2021. However, as mentioned in the previous report 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. At the last QAP, CBUs and Corporate leads were asked to provide a more detailed report outlining trajectories and timescales for completion for any outstanding actions and how they will continue to monitor progress and compliance.

We have reviewed our ‘check and challenge’ process to ensure we monitor any actions we have closed are still compliant. Starting in April 2021 a series of ‘Go See’ visits and ‘mock CQC inspections’ have been scheduled. Multi-disciplinary Teams comprising of nursing, therapies, medical and administration staff will be trained and will review wards, clinical areas and core services to ensure any improvements are embedded and sustained and to prepare for any forthcoming inspections - this will include a strong focus on well led. The results of which will be fed back directly to wards and clinical areas and summarised through monthly divisional and CBU Governance Meetings and PIDA and where appropriate action plans will be developed.

The table below provides an update on progress since the last update to Board in February 2021.

Rating	December 2020 (Agreed at January 2021 QAP)			January 2021 (Agreed at February 2021 QAP)			Change
	Must Do	Should Do	Total	Must Do	Should Do	Total	
Completed	3	40	43	6	47	53	+10
Progressing on schedule	21	40	61	24	40	64	+3
Slightly delayed and/or of low risk	7	12	19	1	5	6	-13
Significantly delayed and/or of high risk	0	0	0	0	0	0	=
TOTAL	**31**	**92**	**123**	**31**	**92**	**123**	

3. CQC UNANNOUNCED RESPONSIVE INSPECTION OF MEDICAL CORE SERVICE

The CQC arrived on site on Wednesday 3rd March 2021 to undertake an unannounced responsive inspection focusing on Medicine Core Service. The team consisting of six inspectors based themselves on site and spent time on the wards meeting with staff, patients and senior managers.

At the commencement of the onsite visit CQC confirmed the areas they would be focussing on which were:

- Incidents
- Staffing
- Nutrition and hydration
- Leadership and culture
- Mental Health provision
- Discharge

Initial verbal and subsequent written feedback was positive particularly in relation to the standards of nursing care they observed and the Inspectors commented they found the Urgent Care CBU triumvirate a ‘strong team’ despite them only being together a relatively short time.

There were some small individual queries on the day of the inspection which we have subsequently responded to and 22 data requests following the inspection, and these have all been submitted to CQC as requested.

The CQC will publish an inspection report in relation to their visit, no timescales have been established yet, however this report is unlikely to result in a change to any of our CQC ratings published following the 2019 inspection.

4. CQC ENGAGEMENT

We continue to have regular engagement meetings with the CQC via MS Teams, we last met with CQC Thursday 11th March 2021 at this meeting we discussed:

- Update in relation to Covid-19 pandemic / current trust position on compliance / key risks
- Update in relation to specific incidents
- Update on any governance process or senior leadership team changes
- Update on Trust response to Ockenden Report.

We also provided CQC with copies of a recent IPC / Covid-19 Gold Command update, recent Urgent and Emergency Care performance and an update in relation to the Ockenden Report.

5. USE OF RESOURCES UPDATE

Current Position

The Use of Resources Action Plan was reviewed by FP&I committee in January 2021, the table below demonstrates progress made since the last report. There are six areas for improvement and 17 individual actions. The table an overview of the status of the actions, there has been no further changes since the last report presented in this report to Board in February 2021

Rating	December 2020	January 2021	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 is one area highlighted BRAG rated as 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

6. RECOMMENDATIONS

The Board of Directors are asked to note the current position against the CQC Improvement Plan, future reporting arrangements and initial feedback in relation to the recent unannounced responsive inspection of Medicine Core Service.

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	29 MARCH 2021
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The committee endorsed proposals for the 2021-22 Financial Plan, which include a holding position for budgetary control, whilst the Trust awaits further guidance from NHSEI. The outline plan includes a number of assumptions that have been applied across the whole year. A more detailed plan will be submitted to FP&I in April '21, which will reflect the latest NHSE/I guidance.

ADVISE

- The Trust's current IT strategy is due a refresh in 2021 and the committee were presented with a new outline strategy, which will run from 2021-2024. The committee welcomed the ambition and direction that was set out, but have requested greater assurance in regards to how the strategy can be delivered, with a focus upon financial investment and governance. It was requested by the committee that the strategy links more explicitly to the Trust's strategic objectives.
- The Trust's forecast year end position has changed at month 11, and the Trust is now forecast to deliver a breakeven position for 2020-21. This is primarily due to the value of the Annual Leave being carried forward and assumes that this is being fully funded. Within month 11 the Trust delivered a surplus, and an increase in non-NHS income has contributed towards this.
- CIP savings for the year are forecast to be £80K below target, which can be attributed to the impact of Covid-19. CIP savings for the year are forecast exceed £1.5M, which demonstrates good progress overall, which the committee acknowledged and would like to see this progress continue in 2021-22.
- The committee received an update in regards to our estates and facilities performance, using model hospital data as a benchmark. Realistic potential for improvement has been identified in several areas, particularly in regards to laundry services, water and waste, which will be explored further and reported back to FP&I through the estates committee. FP&I would welcome the approach taken to use model hospital data and apply this is other areas as well as estates.
- The committee received an update on Capital expenditure, which year to date at the end of February was £8,228K. It is expected that all capital resources, totalling £11,736K will be fully utilised by the end of the year. The committee have requested an accompanying high-level narrative that explains the full distribution of capital investment and the impact this has had for the Trust, throughout 2020-21.
- It was reported that the Trust's critical care surge has de-escalated from level 3 to level 1 and the Trust is therefore planning to restart electives programmes. The Trust's number of 52-week waiters has risen to 91, but this represents only a small percentage of the total number of 52-week waiters across Cheshire & Mersey, which currently stands at 12,000. The Committee has requested further insight in regards to referral rates, that appears to have remained low in comparison to pre-covid levels.
- The Trust's performance in urgent care continues to be positive, particularly in regards to incidences of corridor care, which remains zero.

- The Committee approved the proposals for amending the reporting line of IPR indicators to FP&I. The assurance committee chairs welcomed the iterative improvements being made to the IPR and highlighted some further opportunities for changes in the way the IPR can be used more effectively.

ASSURE

- At the request of the committee the control measures and mitigating actions relating to SO3 have been updated within the Board Assurance Framework to reflect the most up to date position, and this has resulted in a reduction of the risk score.

New Risks identified at the meeting:
None

Review of the Risk Register: *No action taken*

Operations

Access

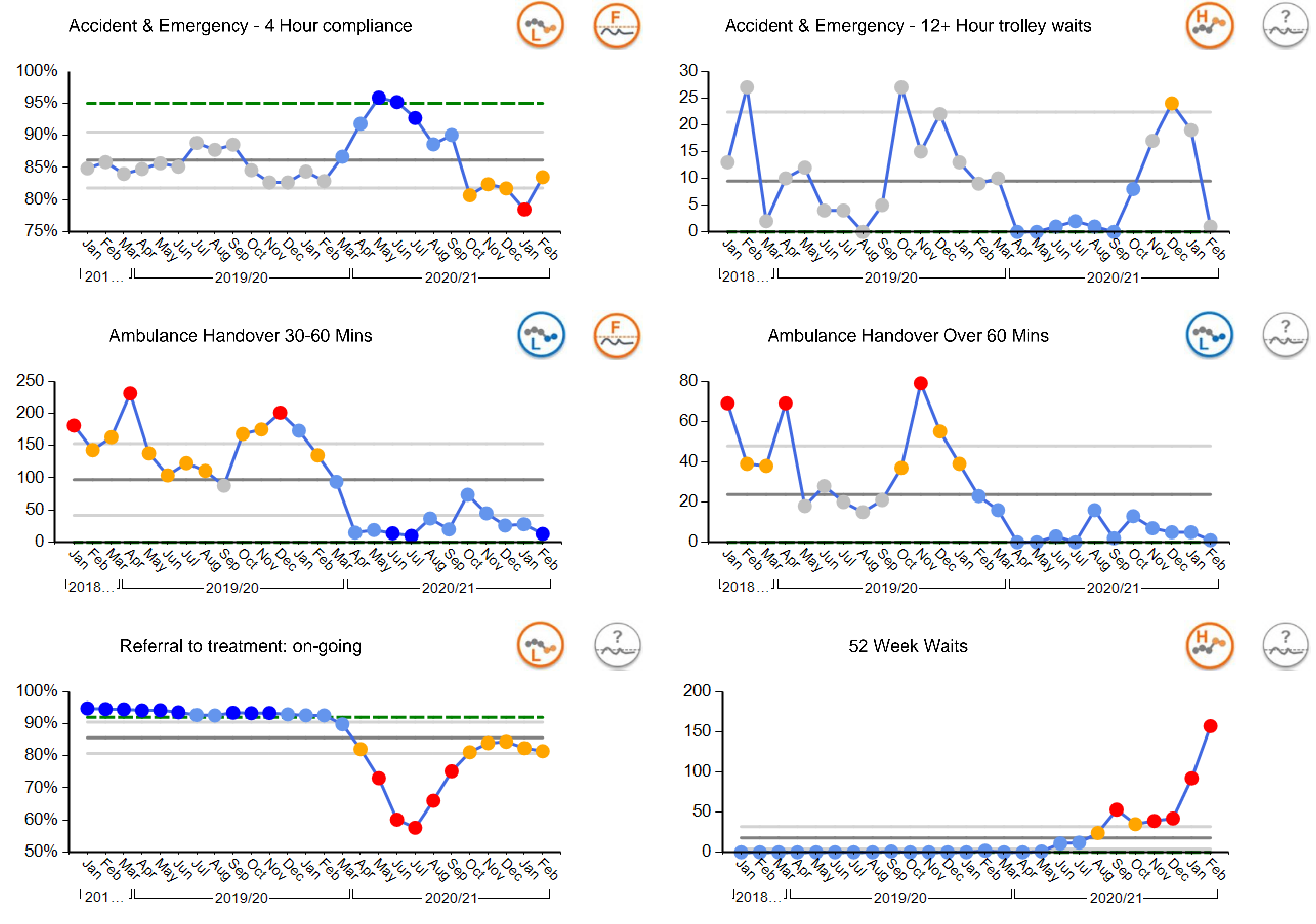
Analyst Narrative:

Although the Ambulance Handover 30-60 Mins is failing its assurance measure, this is related to historic performance as recent performance is showing positive variation. The A&E 4 hour compliance metric continues to show failing assurance but there has been a notable improvement in February. This improving A&E performance is also demonstrated by a reduction in 12 hour trolley waits, with just 1 reported in February. An improving position is also noted for diagnostic waits and cancelled operations.
The third wave of the Covid pandemic has caused further deterioration in the RTT performance, as was expected due to the suspension of all but clinically urgent and cancer treatment.
As a result of the recent MIAA audit into the stroke 90% indicator, this metric will now be reported 1 month in arrears to allow sufficient time for robust validation, therefore the latest data relates to January.

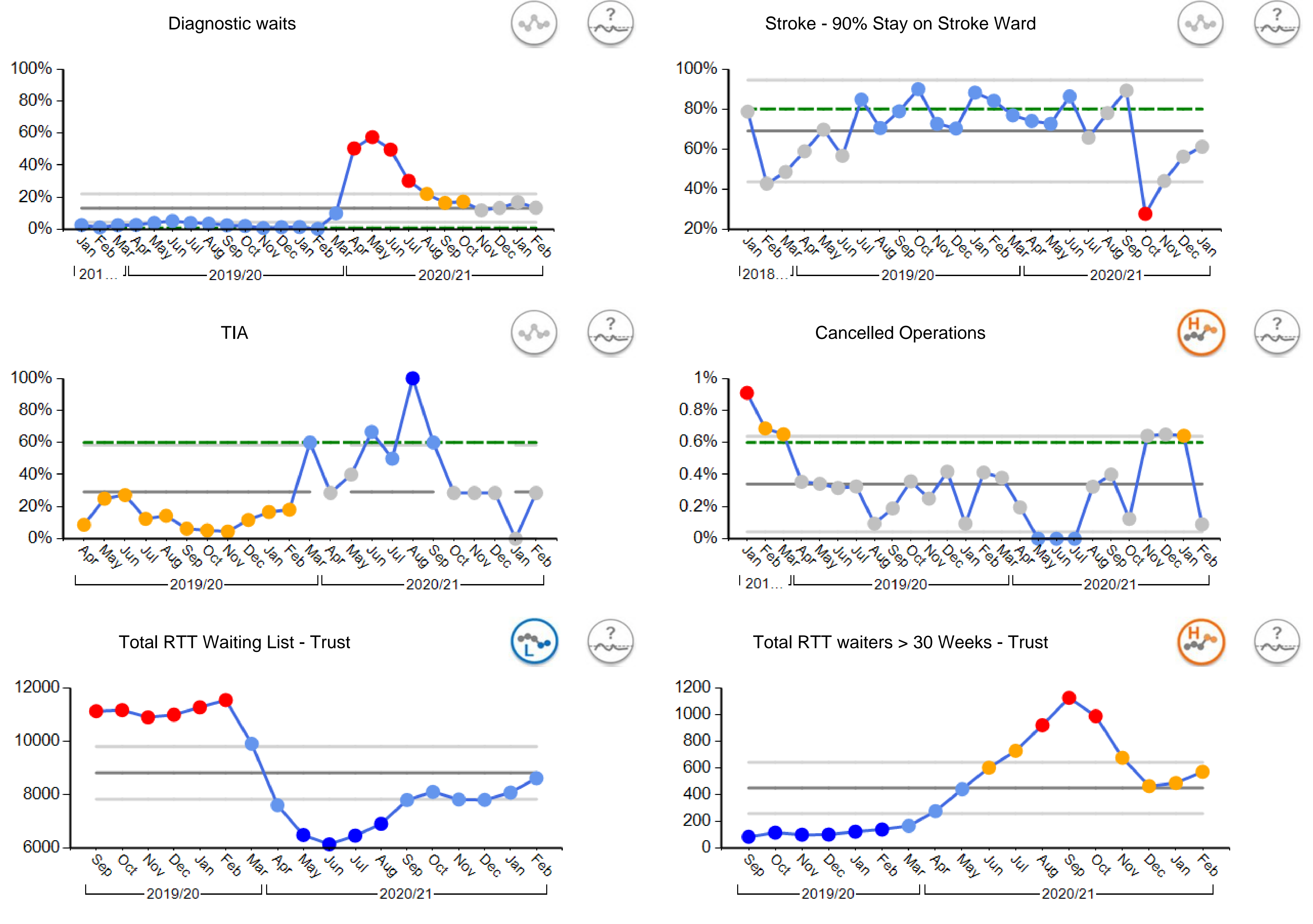
Operational Narrative:

The stroke/TIA action plan has been split this month to report the two indicators separately. Both action plans include the recommendations from the MIAA audit. An action plan relating to RTT has also been included. The Trust performance against the national 4-hour standard in ED began to recover throughout February; YTD performance against the standard is 87.5% and 81.7 % for Q4 20/21 as the end of February 2021. ED attendances at SDGH are plateauing, however the number of arrivals by ambulance and the number of majors presentations increased in month; there has also been some recovery in ODGH attendances. The assessment areas (SDEC) utilisation has increased significantly in month with CDU usage reaching 160 patients the week commencing 22nd February; this has had an overall positive impact on 4-hour performance. A number of actions have been developed to support recovery of the ED 4 hour standard which were presented to FP&I Committee.

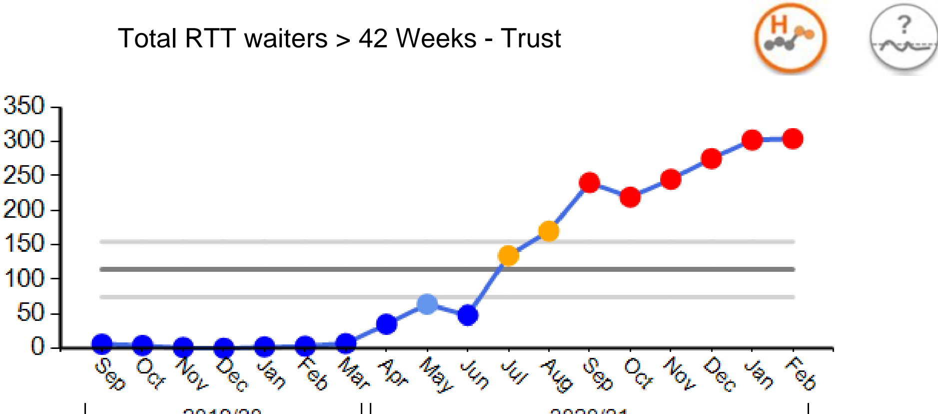
	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Accident & Emergency - 4 Hour compliance	95%	83.5%	1078	Feb 21		95%	78.5%	Jan 21	95%	87.3%	
Accident & Emergency - 12+ Hour trolley waits	0	1	1	Feb 21		0	19	Jan 21	0	73	
Ambulance Handover 30-60 Mins	0	13	13	Feb 21		0	28	Jan 21	0	301	
Ambulance Handover Over 60 Mins	0	1	1	Feb 21		0	5	Jan 21	0	52	
Referral to treatment: on-going	92%	81.5%	1598	Feb 21		92%	82.4%	Jan 21	92%	76%	
52 Week Waits	0	157	157	Feb 21		0	92	Jan 21	0	157	
Diagnostic waits	1%	13.5%	444	Feb 21		1%	17%	Jan 21	1%	25.7%	
Stroke - 90% Stay on Stroke Ward	80%	61.3%	12	Jan 21		80%	56.3%	Dec 20	80%	66.2%	
TIA	60%	28.6%	5	Feb 21		60%	0%	Jan 21	60%	46.4%	
Cancelled Operations	0.6%	0.1%	1	Feb 21		0.6%	0.6%	Jan 21	0.6%	0.3%	
Total RTT Waiting List - Trust		8616	8616	Feb 21			8079	Jan 21		8616	
Total RTT waiters > 30 Weeks - Trust		571	571	Feb 21			487	Jan 21		571	
Total RTT waiters > 42 Weeks - Trust		304	304	Feb 21			302	Jan 21		304	



Accident & Emergency - 4 Hour compliance
100%
95%
90%
85%
80%
75%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2019/20
2020/21
Accident & Emergency - 12+ Hour trolley waits
30
25
20
15
10
5
0
2018...
2019/20
2020/21
Ambulance Handover 30-60 Mins
250
200
150
100
50
0
2018...
2019/20
2020/21
Ambulance Handover Over 60 Mins
80
60
40
20
0
2018...
2019/20
2020/21
Referral to treatment: on-going
100%
90%
80%
70%
60%
50%
201...
2019/20
2020/21
52 Week Waits
200
150
100
50
0
2018...
2019/20
2020/21



Diagnostic waits
100%
80%
60%
40%
20%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2019/20
2020/21
Stroke - 90% Stay on Stroke Ward
100%
80%
60%
40%
20%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2018…
2019/20
2020/21
TIA
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21
Cancelled Operations
1%
0.8%
0.6%
0.4%
0.2%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2019/20
2020/21
Total RTT Waiting List - Trust
12000
10000
8000
6000
Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21
Total RTT waiters > 30 Weeks - Trust
1200
1000
800
600
400
200
0
Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21



Total RTT waiters > 42 Weeks - Trust
H
?
350
300
250
200
150
100
50
0
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2019/20
2020/21

Operations

Cancer

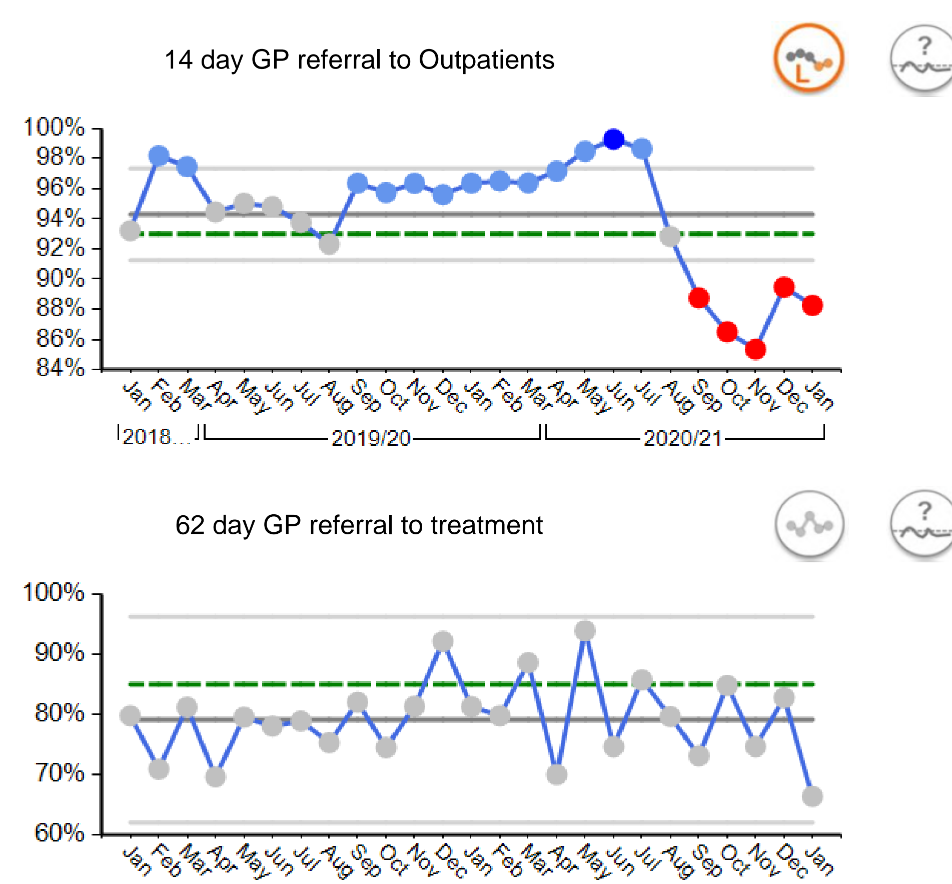
Analyst Narrative:

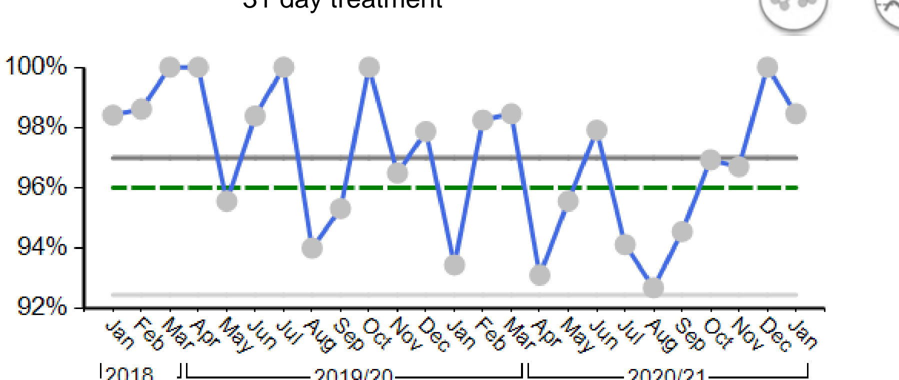
The 14 day GP referral to Outpatients continues to show recent negative variation with a decline in performance in January. This remains a cause for concern. The 31 day treatment was again ahead of plan in January, this performance needs to be sustained to be assured. Performance on the 62 day GP referral indicator remains variable.

Operational Narrative:

Compliance with the 62 day GP Referral indicator has been impacted by an influx of patients who postponed treatment before Christmas. In addition to these patient initiated delays, the primary cause was delays to diagnostics with endoscopy capacity in particular still a challenge. This contributed to late tertiary referrals which impacted our performance further.
See supplementary action plan relating to the 14 day GP referral to Outpatients indicator.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
14 day GP referral to Outpatients	93%	88.3%	78	Jan 21	L	93%	89.5%	Dec 20	93%	91.7%	?
31 day treatment	96%	98.5%	1	Jan 21		96%	100%	Dec 20	96%	96.4%	?
62 day GP referral to treatment	85%	66.4%	19	Jan 21		85%	82.8%	Dec 20	85%	78%	?


14 day GP referral to Outpatients
100%
98%
96%
94%
92%
90%
88%
86%
84%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2018...
2019/20
2020/21
62 day GP referral to treatment
100%
90%
80%
70%
60%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2018...
2019/20
2020/21


31 day treatment
100%
98%
96%
94%
92%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2018...
2019/20
2020/21

Operations

Productivity

Analyst Narrative:

Despite Theatre Utilisation on both sites continuing to fail their assurance measure, both have demonstrated a much improved position in February.
The DNA rate, while continuing to show recent negative variation, has also improved in February and is ahead of plan. Additionally, the A&E Conversion rate, which also shows recent negative variation, has reduced in month and is in line with the plan. Despite the challenges caused by the third wave of the pandemic, the number of stranded and super-stranded patients are both showing recent positive variation and continued on an improving trajectory in February. Bed Occupancy at ODGH continues to fail its assurance measure and shows recent special cause concern.

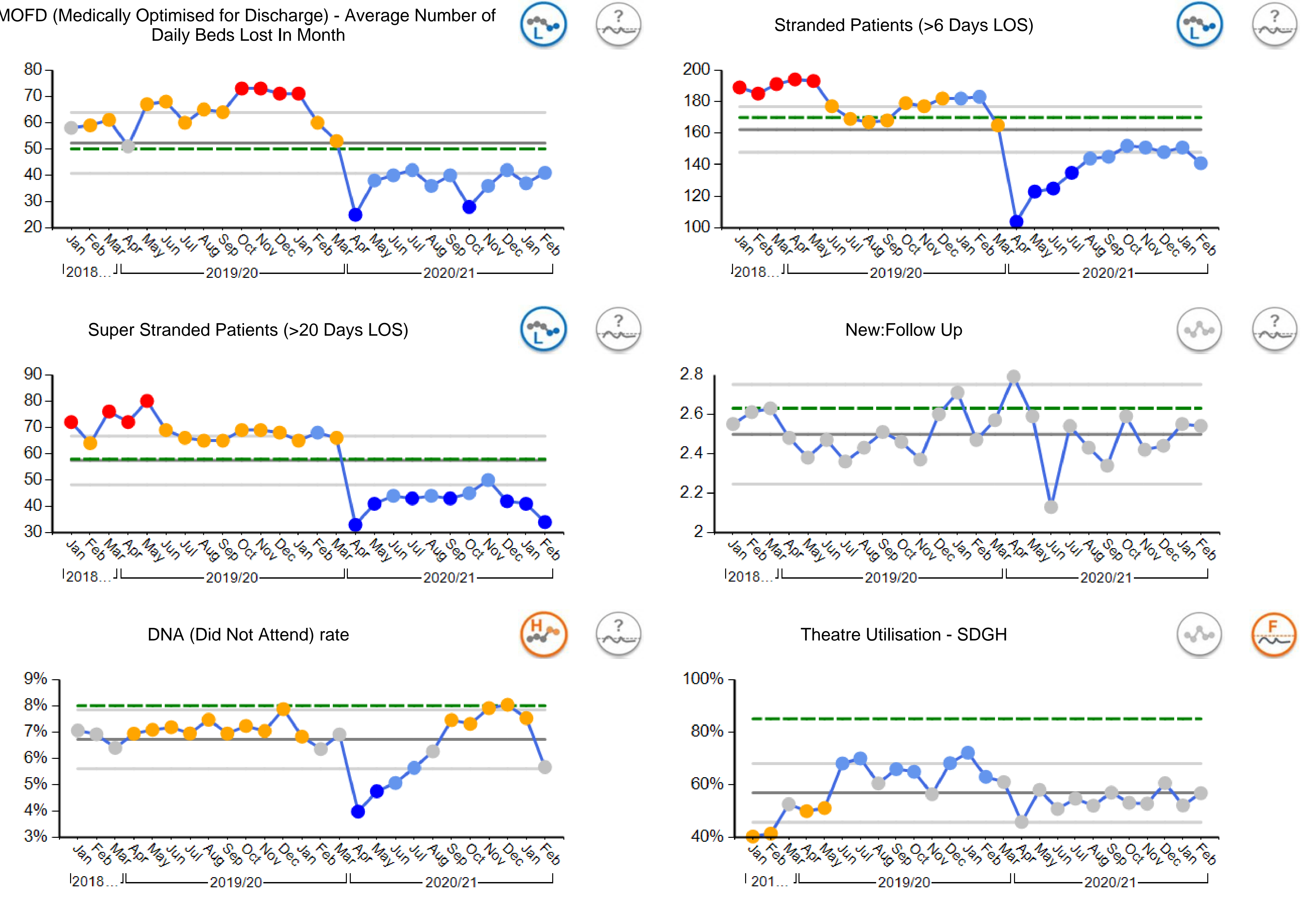
Operational Narrative:

An action plan has been developed to reflect the work to address Length of Stay, including Stranded/Super-Stranded patients. The action plans relating to Bed Occupancy- ODGH and Theatre Utilisation at both sites have been updated and are included.

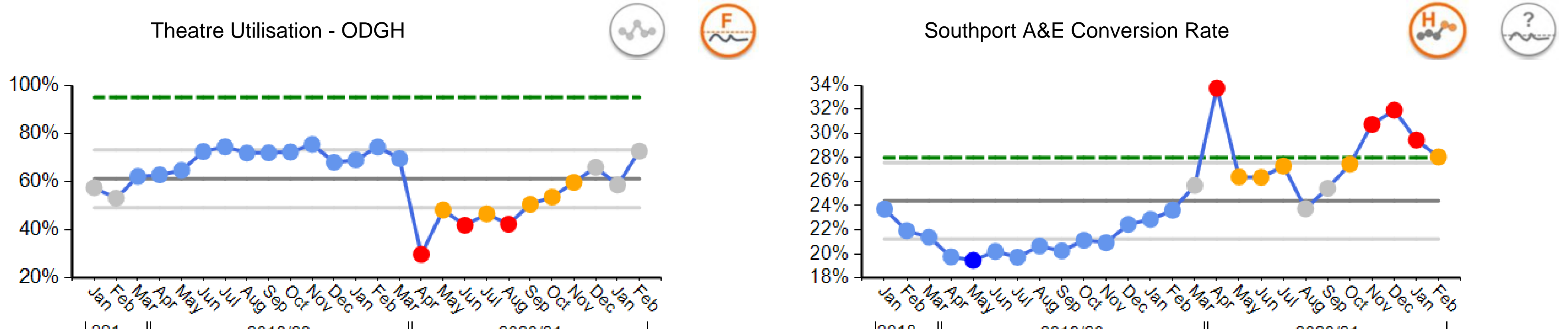
Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Bed Occupancy - SDGH	93%	85.1%	N/A	Feb 21	L	93%	84.6%	Jan 21	93%	76.3%	?
Bed Occupancy - ODGH	60%	37.8%	N/A	Feb 21	L	60%	38.3%	Jan 21	60%	32.6%	F
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	41	41	Feb 21	L	50	37	Jan 21	50	37	?
Stranded Patients (>6 Days LOS)	170	141	141	Feb 21	L	170	151	Jan 21	170	1519	?
Super Stranded Patients (>20 Days LOS)	58	34	34	Feb 21	L	58	41	Jan 21	58	460	?
New:Follow Up	2.63	2.5	N/A	Feb 21		2.6	2.6	Jan 21	2.63	2.5	?
DNA (Did Not Attend) rate	8%	5.7%	1132	Feb 21	H	8%	7.5%	Jan 21	8%	6.5%	?
Theatre Utilisation - SDGH	85%	56.9%	N/A	Feb 21		85%	52.2%	Jan 21	85%	54.4%	F
Theatre Utilisation - ODGH	95%	72.6%	N/A	Feb 21		95%	58.6%	Jan 21	95%	53%	F
Southport A&E Conversion Rate	28%	28%	987	Feb 21	H	28%	29.5%	Jan 21	28%	28%	?

Bed Occupancy - SDGH

Bed Occupancy - ODGH

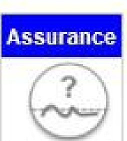


MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month
Stranded Patients (>6 Days LOS)
Super Stranded Patients (>20 Days LOS)
New:Follow Up
DNA (Did Not Attend) rate
Theatre Utilisation - SDGH
2018…
2019/20
2020/21



Theatre Utilisation - ODGH
100%
80%
60%
40%
20%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
201...
2019/20
2020/21
Southport A&E Conversion Rate
34%
32%
30%
28%
26%
24%
22%
20%
18%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2018...
2019/20
2020/21

Stroke—90% Stay on Stroke Ward

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
Stroke - 90% Stay on Stroke Ward	80%	61.3%	12	Jan 21		80%	56.3%	Dec 20	80%	66.2%	

Stroke - 90% Stay on Stroke Ward

100%, 80%, 60%, 40%, 20%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan

2018… 2019/20 2020/21

Background:

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

Situation:

A further incremental improvement in performance in January, this indicator is now intermittent in assurance and variation.

Issues:

Performance against this quality standard has been impacted throughout COVID, ward 7B has limited isolation capacity and has suffered multiple covid breakouts resulting in part or full closure. Stroke patients have been outlied into 7A, 15A and 15B.

MIAA Audit identified issues with the reporting of this indicator:

- clock start time should be from time patient enters hospital, not decision to admit
- patient's pathways being recorded incorrectly on Medway
- timeliness of validation due to coding delays

Actions:

Addition of an alert to Medway to highlight Stroke admissions to improve oversight—currently with PAS Team for feasibility.

Plans afoot to move Stroke to Ward 15B on 31st March 2021

In response to the MIAA Audit:

To review the feasibility of using SSNAP to calculate the 90% stay. Otherwise to change the BI script to ensure the clock start reflects time of initial attendance.

To report this indicator one month in arrears to ensure adequate time for coding and validation. This would address discrepancies with patient pathways. Due to CCG reporting, this will be discussed and agreed through CCQRM .

Mitigations:

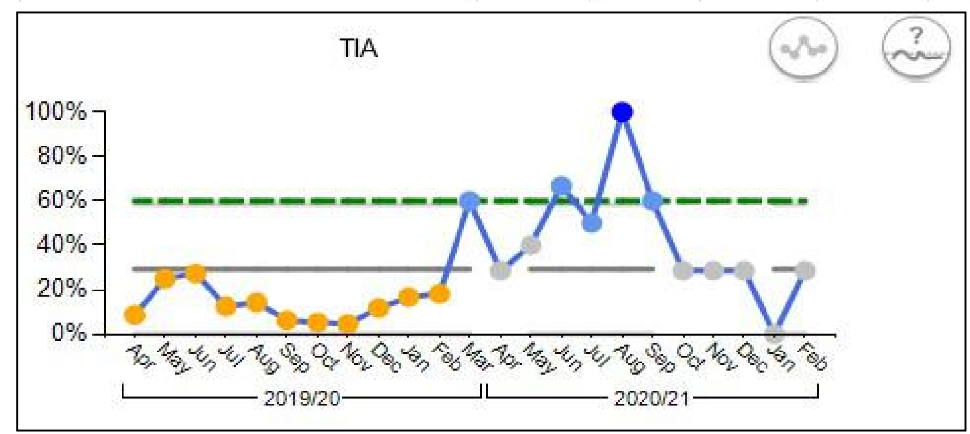
Continue to monitor outliers through bed meeting and transfer any patients to the Stroke ward at earliest opportunity.

To continue to validate stroke patients and breaches weekly with the Lead Stroke Nurse.

ADO will review and approve all submissions to CCG's to ensure information is correct and consistent with internal reporting,

TIA—High risk seen within 24hrs

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
TIA	60%	28.6%	5	Feb 21		60%	0%	Jan 21	60%	46.4%	



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

Situation: This indicator has failed to achieve target since September 2020. There has been an increase in performance in February but 5 patients did not meet the timescale.

Issues:

MIAA highlighted issues regarding the timing of validation of TIA performance, using data that was not validated and subject to change.

The review also highlighted deviation from national guidance in relation to reporting against the TIA quality standards.

A further internal review has highlighted a requirement to review the TIA pathway both internally with the clinical team and the BI team and with commissioners.

Actions:

Reporting will be brought in line with national guidance and a retrospective assessment of TIA performance undertaken back to April 2020.

Task and Finish Group to be established jointly with GP representation, commissioners, clinical team and diagnostics to review the TIA pathway against national quality standards to determine the sustainability of the TIA service in line with the Stroke service review (fragile services)

BI Team to recommend reporting cycle that allows validated data to be used.

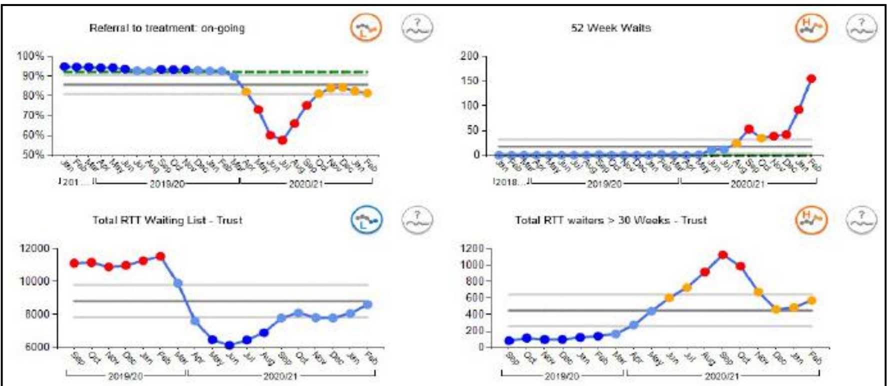
Mitigations:

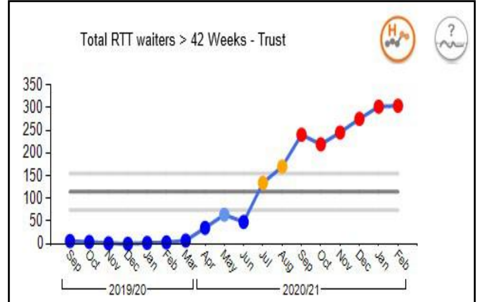
All TIA referrals are clinically triaged by a Consultant and scheduled for next available clinic (same day/next day).

Any patients presenting in ED or ACU are commenced on treatment before they are discharged.

Referral to Treatment

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
Referral to treatment: on-going	92%	81.5%	1598	Feb 21	L	92%	82.4%	Jan 21	92%	76%	?
52 Week Waits	0	155	155	Feb 21	H	0	92	Jan 21	0	92	?
Total RTT Waiting List - Trust		8616	8616	Feb 21	L		8079	Jan 21		8616	?
Total RTT waiters > 30 Weeks - Trust		571	571	Feb 21	H		487	Jan 21		571	?
Total RTT waiters > 42 Weeks - Trust		304	304	Feb 21	H		302	Jan 21		304	?





Background: Indicators relating to the length of time a patient has waited from referral to start of treatment, or if they have not started treatment, the length of time on an open pathway.

Situation: All indicators relating to RTT have been impacted by the Covid-19 pandemic.

Trust RTT performance continues to perform below the 92% National Standard and the number of 30, 42 and 52 week waits has increased.

Issues:

The third wave of Covid and subsequent critical care escalation resulted in only cancer and clinically urgent treatment going ahead in January and February. Critical Care was de-escalated on 12th March 2021 but due to 2 week swabbing delays and shielding staff full patient effect will not be realised until mid April.

15 specialties currently failing to deliver against the 92% National Standard.

Impact of workforce capacity, vacancies and single point of failure in some specialities.

Impact of reduced template capacity due to Covid restrictions and availability of rooms.

Actions:

Review of job plans to maximise capacity.

PAG approval for additional sessions/staffing requirements.

Service reviews, e.g. Ophthalmology.

Improve utilisation of Outpatients and theatres.

Utilise Renacres Theatre capacity.

Increase utilisation in Endoscopy.

The planned Theatre maintenance has been brought forward from May to early April to minimise disruption to theatre sessions.

Review of diagnostics services to ensure capacity meets the demand.

Mitigations:

Recovery plans are in place across all specialities and a Restoration Plan has been submitted.

Risk stratification of all patients.

Weekly PTL meetings to track patients and escalate issues. OSM daily monitoring

Use of virtual appointments where possible

Cancer - 14 day GP Referral to Outpatients

Southport & Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
14 day GP referral to Outpatients	93%	88.3%	78	Jan 21		93%	89.5%	Dec 20	93%	91.7%	

14 day GP referral to Outpatients

Situation: 14 Day cancer performance has failed to achieve plan in January and there has been a slight decline from the December performance. Numbers of patients reported against this target is down 30% compared to the previous month.

31 day treatment achieved plan in January, with 1 patient not achieving 31 day treatment.

The 62 day measure fell significantly in January, to it's lowest level in more than two years.

Issues:

The Trust was not compliant for 62 and 14 day national standards. COVID 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. Increased COVID related delays has resulted in breaches for both upper and lower GI patients. Urology patients coming in on the haematuria pathway are also a concern. These patients have a scan as their first appointment and there are delays requesting this scan due to referrals coming without bloods and then capacity issues for the scans themselves.

Actions:

Activity in endoscopy has returned to pre-COVID levels, but increasing demand has put extra strain on waiting times in department. In addition to restrictions resulting from the need for single-sex lists, there is now staff illness to accommodate. The building of new changing facilities, required for mixed sex lists to resume, is awaiting approval at Business Planning. This work will take 12-16 weeks to complete.

Audit of haematuria pathway to identify reasons for delays to scans. Meeting to take place with CCG about referrals that lack up to date bloods.

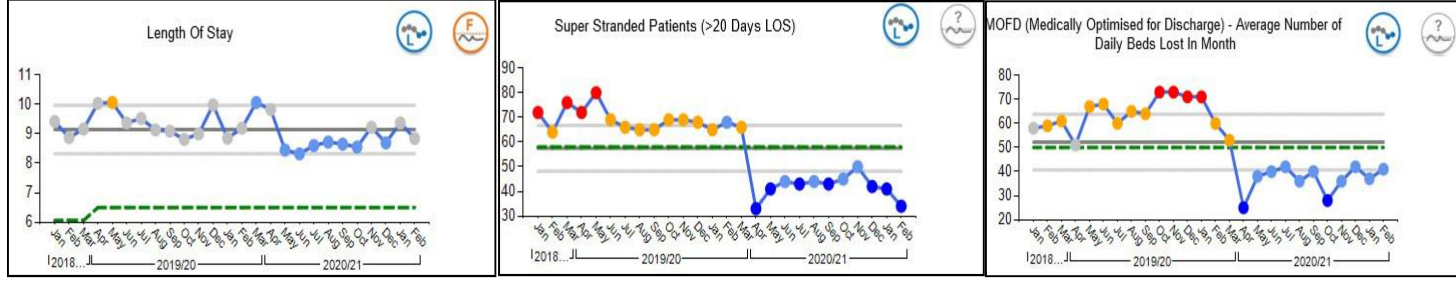
Mitigations:

Weekly monitoring of endoscopy waiting times.

Discussion of TWW breaches at patient level detail now undertaken every week so try to prevent unnecessary delays.

Length of Stay

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
Length Of Stay	6.5	8.8	N/A	Feb 21	L	6.5	9.4	Jan 21	6.5	8.8	F
Super Stranded Patients (>20 Days LOS)	58	34	34	Feb 21	L	58	41	Jan 21	58	460	?
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	41	41	Feb 21	L	50	37	Jan 21	50	37	?



Background:

The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO and 1 Day Length of Stay. Impacted by both Super Stranded patients and MOFD indicators.

Situation:

The current average LOS is 9.1. Significant improvements in both Super Stranded and MOFD metrics since April 2020.

Issues:

The number of super stranded patients at SDGH has decreased significantly since April 2020.

With the exception of a slight increase in November 2020, following the second wave of COVID the trust has maintained the average number of LLOS / super-stranded under the lower control limit.

The number of patients MOFD in the bed base has been maintained below the lower control limit since April 2020. Like LLOS, this indicator has been supported by the changes at a national level to the provisions for discharging patients when they longer require acute hospital care.

If national funding for discharge solution is reduced or removed and CCGs can no longer continue to support designated setting provision and "Home First" then these indicators are likely to witness a rapid deterioration and numbers of delays and LLOS are likely to return to pre-pandemic levels.

Actions:

Continue to implement national guidance for discharge published during Covid pandemic.

Continue to utilise daily system huddles, attended by senior leaders over 7 days to support flow through the hospital.

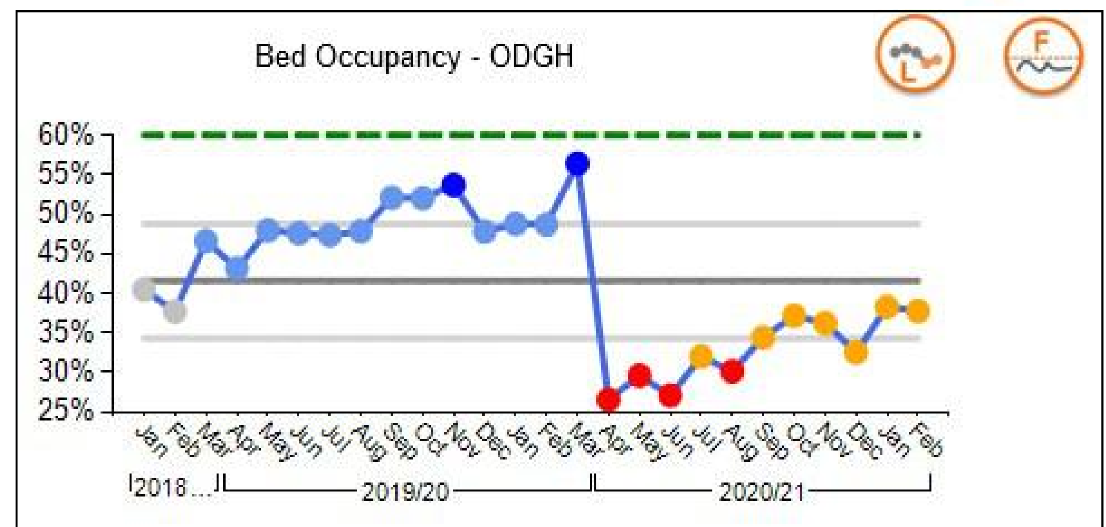
Use of Discharge Task Force, an on-site peripatetic MDT reviewing all patients ready for discharge or approaching. The outcome measures are being collected under a PDSA project .

Mitigations:

Patients are managed based on their "reason to reside"; when they no longer meet the range of conditions under this criterion, they must be placed into an alternative setting for discharge planning if they cannot be discharged to their own home.

Bed Occupancy—ODGH

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
Bed Occupancy - ODGH	60%	37.8%	N/A	Feb 21		60%	38.3%	Jan 21	60%	32.6%	



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. Both F Ward and H Ward remained closed in February 2021 as the Trust continued to cancel some elective lists to manage the third wave of the Covid pandemic. These wards are therefore excluded from the occupancy figure.

Issues:

A Medway issue mean the number of beds open on G Ward is unable to be flexed as required. This has resulted in lower occupancy figures on this ward. The occupancy is calculated based on 20 beds while only 14 were open.

Overall occupancy on this site is impacted by Maternity and Paediatrics whose occupancy is low due to high levels of day case activity. Due to the closure of F and G wards this is having a greater impact on overall occupancy.

Actions:

System C are investigating the system error on Medway. The Clinical Systems Manager continues to work with System C to expedite this issue but there is currently no date for this to be rectified.

Theatre activity to be reinstated and will increase incrementally from the 15th March to be at full capacity by mid April.

The calculation of bed occupancy in Paediatric and Maternity areas has been reviewed and the Trust continues to follow national guidance , therefore these areas will always affect overall ODGH occupancy.

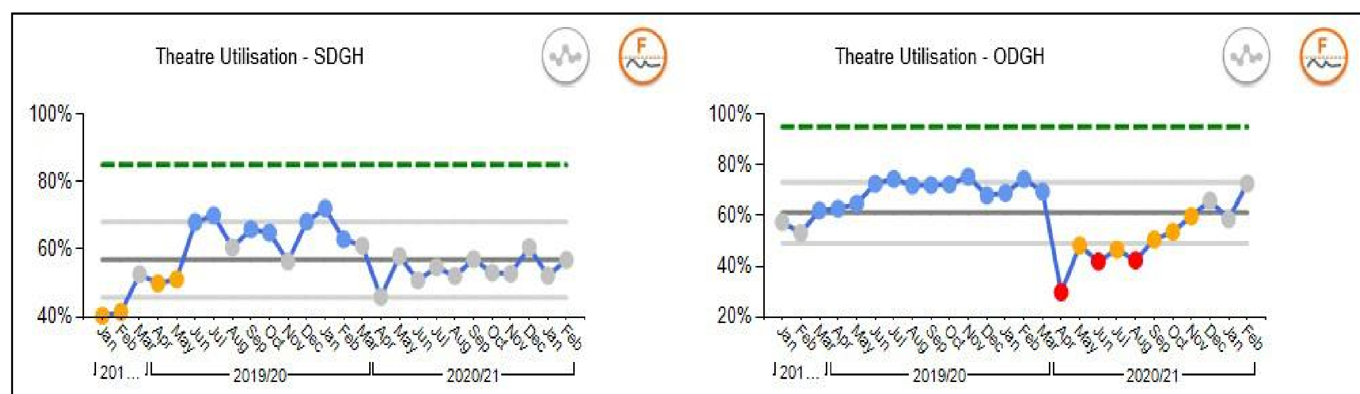
Mitigations:

BI have created a number of internal reports to look at ward bed occupancy on a daily and monthly basis. It also shows the constitution of activity within each ward which helps to explain how each ward is being utilised for patient care.

Theatre Utilisation

Southport & Ormskirk Hospital NHS
NHS Trust

Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Theatre Utilisation - SDGH	85%	56.9%	N/A	Feb 21		85%	52.2%	Jan 21	85%	54.4%	
Theatre Utilisation - ODGH	95%	72.6%	N/A	Feb 21		95%	58.6%	Jan 21	95%	53%	



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

Increase in utilisation on both sites in February, with performance at ODGH at the highest level since February 2020.

Issues:

Utilisation in February on both sites continued to be impacted by the third wave of the Covid pandemic. All theatre activity, with the exception of cancers and clinically urgent procedures was cancelled due to the requirement to support Critical Care escalation.

Theatre utilisation on the Southport site was impacted by late starts in February, of which the biggest cause was patients not being ready on the ward. This was due to difficulties allocating beds to patients and patients not being brought in too early due to Covid restrictions.

Early finishes also impacted the utilisation, often due to cases not running as predicted.

Actions:

Monthly review and validation of theatre data.

Ongoing engagement of clinical teams; weekly meetings supported by AMD and a number of Specialty representatives.

The Business Plan for 2021/22 contains Review of the pathway to include both surgical admission and forward wait areas to reduce the likelihood of delays.

Mitigations:

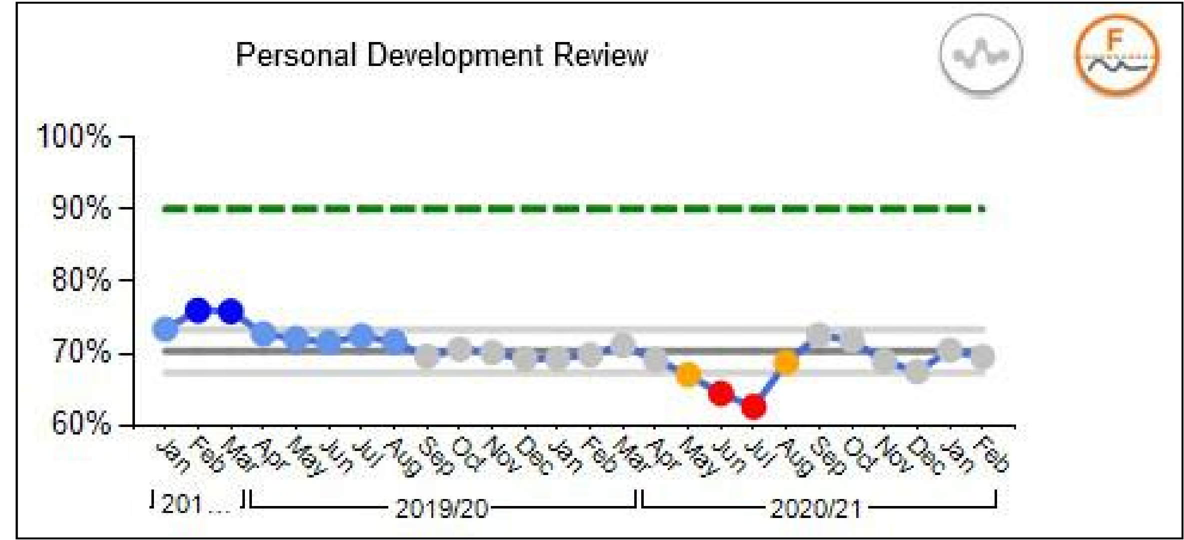
Additional scrutiny of theatre start times and underruns, being led by clinicians and monitored weekly.

Continued monitoring of specialty level KPI's through the Theatre Efficiency meeting and reported into PIDA.

Non Medical Appraisal/Personal Development Reviews

Southport & Ormskirk Hospital 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
Personal Development Review	90%	69.5%	N/A	Feb 21		90%	70.4%	Jan 21	90%	69.1%	F



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:

Action plan has been developed from the Deep Dive and recent internal audit recommendations. By September 2021, the Trust should expect

- All data reviewed in ESR to support accurate reporting information
- Updated training package and communications to managers & staff
- Improvements to the Appraisal policy informed by recommendations

Mitigations:

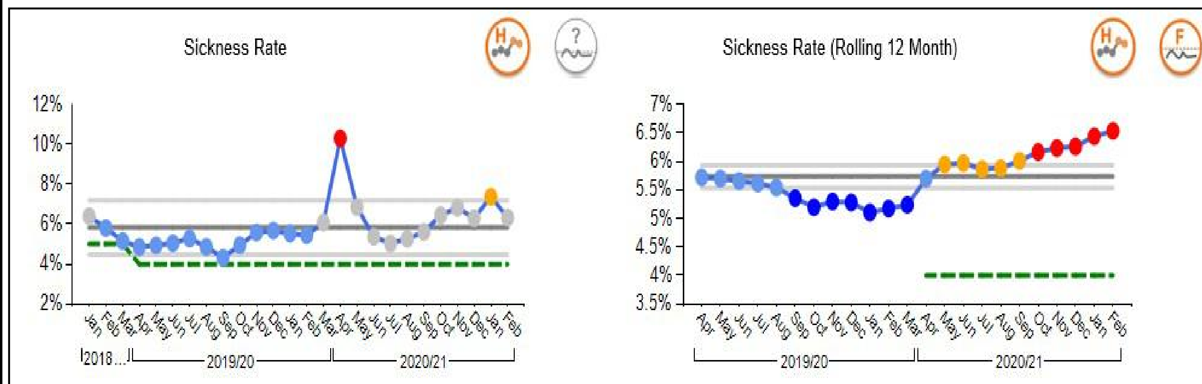
MIAA Audit undertaken Nov-Dec 2020

Bimonthly audit review on quality of appraisals to commence in August 2021

Sickness Absence

Southport & Ormskirk Hospital NHS Trust

Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness Rate	4%	6.3%	N/A	Feb 21	H	4%	7.4%	Jan 21	5%	6.5%	?
Sickness Rate (Rolling 12 Month)	4%	6.5%	N/A	Feb 21	H	4%	6.4%	Jan 21	4%	6.1%	F



Background: The Trust has invested a great deal into its engagement and wellbeing offer to staff recently, as well as achieving a high take up of covid vaccine. However, it now has the highest sickness rates compared to other Trusts in the Cheshire and Merseyside region.

Situation: There was been a peak in early February 2021 with 373 staff were absent. However, more recently there has been a recent reduction in absence, so as at 9th March 2021, there are 311 staff absent due to sickness related issues. This recent reduction in absence coincides with the reopening of schools. As at 9th March 2021, the Trust absence rate is around 10% (6% non-covid and 4% covid) compared to STHK 8% (5% non-covid and 3% covid) and LUFT 7.75% (3.6% non-covid and 4.15% covid).

Issues:

Recording of covid-related absence inconsistent with other Trusts

'Pausing' of the management of attendance as part of the national social partnership agreement

Staffing shortages in the HR Advisory service

Policies and procedures not agile/responsive to the current situation

Actions:

- Reporting and data quality : Remove shielders from absence data, create post-covid absence category, ensure no 'unknown' reasons against any long term absences
- CBU trajectory to reduce absence informed by plans against all long term and persistent short term absentees
- Additional HR/OD support for managers, including dedicated HR Advisor per CBU
- Review of special leave and flexible working policies

Mitigations:

MIAA Audit undertaken October 2020

Finance

Finance

Analyst Narrative:

Two indicators are failing the assurance measure; Distance from agency spend cap and % Agency Staff (cost), both of which are due to historical performance pre 2020/21. The % Agency staff (cost) whilst showing failing assurance is showing positive variation, although there has been a marginal increase in February. The pay run-rate, non-pay run rate and bank/agency run rate are all showing recent negative variation but all have decreased in February. The Distance from Control Total and I&E surplus/deficit/total revenue are both showing recent positive variation with upturns in February. The current financial agreements are impacting on most measures so assurance and variation are not entirely representative in this section of the report.

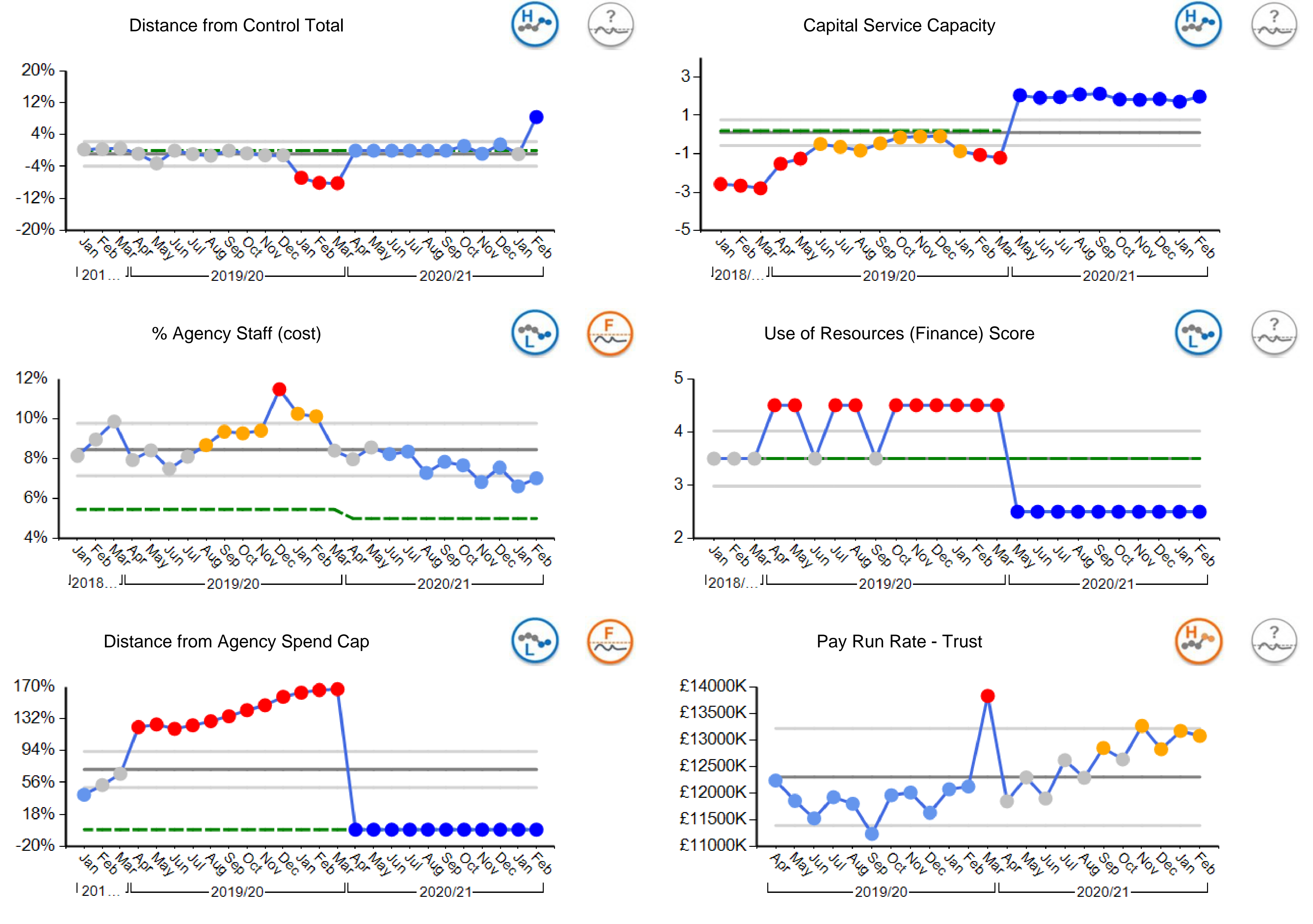
Operational Narrative

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 forecast deficit has been changed to reflect deterioration in the annual leave (A/L) accrual (from £0.6m to a forecast of £3.6m) and non NHS income (from £0.9m to £1.4m). The non NHS income loss of £1.4m has now been funded. A partial funding (£2.2m) of the A/L accrual has been received in March 2021 and any further funding will be dependent of the final year end figure. The ability of the Trust to break-even will depend upon the funding of the A/L accrual. If the full funding is not received, and a year-end deficit is incurred, then this will be an “allowable ” deficit.
Distance from Control Total – for the purposes of this report the Control Total is the Month 7-12 Financial Plan. The in month position reflects additional income of £1.2 million (5 months of £1.4 million non NHS income funding). The forecast break-even position means that this metric will be over achieved.
I&E Surplus or deficit/total revenue – a surplus of 6.8% has been incurred in February. This reflects the £1.2 million income as above.
Liquidity – no change on January position
% Agency Staff Cost (%) – increase in month reflecting the continued need for agency staff during staff sickness, self- isolation and the difficulty in recruiting permanently to substantive posts. International nurse recruitment of nursing staff is expected to have a positive impact on this metric in 2021/22 but the inability to appoint to key medical posts is continuing to adversely affect this metric.
Capital service capacity –no material change from January.
Pay Run Rate – reduction forecasted due to the catch up of the nurse incentive scheme payment made in January
Non Pay Run Rate – Depreciation benefit arising as a result of updating the asset register at Quarter 3. Other non pay items have also reduced across a number of areas.
Bank and agency spend – reduction for same reason as pay run rate explanation.

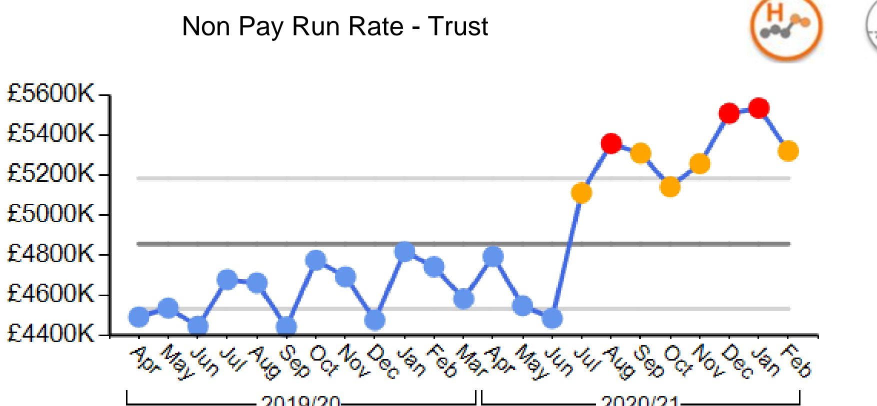
Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
I&E surplus or deficit/total revenue		6.8%	N/A	Feb 21		-4.2%	-3.6%	Jan 21		6.8%	
Liquidity		-18	N/A	Feb 21		-106	-19	Jan 21		-18	
Distance from Control Total	0%	8.4%	N/A	Feb 21		0%	-0.9%	Jan 21	0%	8.4%	
Capital Service Capacity		1.98	N/A	Feb 21		0.2	1.72	Jan 21		1.98	
% Agency Staff (cost)	5%	7%	N/A	Feb 21		5%	6.6%	Jan 21	5%	7.6%	
Use of Resources (Finance) Score	3	2	N/A	Feb 21		3	2	Jan 21	3	2	
Distance from Agency Spend Cap	0%	0%	N/A	Feb 21		0%	0%	Jan 21	0%	0%	
Pay Run Rate - Trust		£13,075K	N/A	Feb 21			£13,171K	Jan 21		£138,772 K	
Non Pay Run Rate - Trust		£5,319K	N/A	Feb 21			£5,533K	Jan 21		£56,357K	
Bank & Agency Run Rate - Trust		£2,542K	N/A	Feb 21			£2,752K	Jan 21		£24,741K	

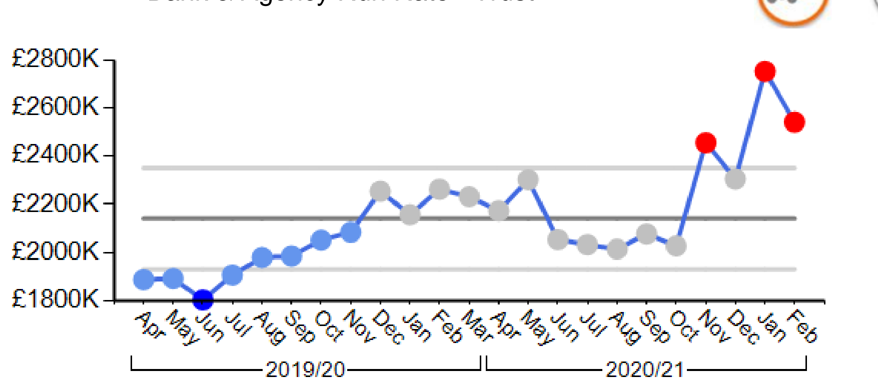
I&E surplus or deficit/total revenue

Liquidity



Distance from Control Total
20%
12%
4%
-4%
-12%
-20%
2019/20
2020/21
Capital Service Capacity
3
1
-1
-3
-5
2019/20
2020/21
% Agency Staff (cost)
12%
10%
8%
6%
4%
2019/20
2020/21
Use of Resources (Finance) Score
5
4
3
2
2019/20
2020/21
Distance from Agency Spend Cap
170%
132%
94%
56%
18%
-20%
2019/20
2020/21
Pay Run Rate - Trust
£14000K
£13500K
£13000K
£12500K
£12000K
£11500K
£11000K
2019/20
2020/21


Non Pay Run Rate - Trust
£5600K
£5400K
£5200K
£5000K
£4800K
£4600K
£4400K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21


Bank & Agency Run Rate - Trust
£2800K
£2600K
£2400K
£2200K
£2000K
£1800K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB049/21	FOI Exempt	NO
Report Title	DIRECTOR OF FINANCE REPORT - MONTH 11 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 the financial position for February 2020 (month 11) and provides an update on the current position with financial planning for 2021/22.

Executive Summary

Month 11 has delivered a surplus of £1.4 million (month 11 YTD surplus is £0.7 million). This is mainly as a result of for "non NHS income" (£1.166 million actioned in Month 11; £1.4 million received for H2) and non-recurrent issues such as PDC dividend and depreciation. The underlying position has remained relatively stable despite a reduction in the number of Covid patients in our hospitals.

Our current forecast is breakeven, however this assumes the full value of our proposed annual leave accrual is fully funded, and this remains the most material factor in delivering the year end break-even forecast. Business rules for 2021/22 were released on 25 March, and supporting financial data is still being released and as yet is incomplete. Whilst an indicative financial plan was considered at FP&I, it was agreed to note the work done to date and refresh this with once all the information becomes available for consideration at April FP&I and then subsequent approval at May Board. In the meantime, existing budgets will effectively be rolled over.

Recommendations

The Board is asked to receive and note the report

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	Presented By:
Kevin Walsh	Bill Gregory

Finance Report – Month 11 2020/21

1. Purpose

1.1. This report provides the Board with the financial position for January 2021 (month 10) and provides an update on the current position with financial planning for 2021/22.

2. Executive Summary

2.1. Month 11 has delivered a surplus of £1.4 million (month 11 YTD surplus is £0.7 million).

2.2. There have been a number of issues this month contributing to the £1.4 million in month surplus.

2.3. Income levels have increased, mainly in respect of funding received for "non NHS income" (£1.166 million actioned in Month 11; £1.4 million received for H2)

2.4. Monthly expenditure levels have decreased in February, mainly on non recurrent issues such as PDC dividend and depreciation.

2.5. Due to funding of non NHS income (£1.4 million) and projected funding of the annual leave accrual (£3.6 million) the Trust is now forecasting a break-even position on its underlying budget, provided the annual leave accrual is fully funded.

3. Income & Expenditure for Months 7-12 (H2)

3.1. The following table illustrates performance to date for the second half of the year:

I&E (Including R&D)	HALF YEAR	M7-11			MONTH 11		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	90,685	75,562	75,672	110	15,118	15,186	68
PP, Overseas & RTA	374	311	267	(44)	62	29	(33)
Other Income	5,526	4,753	4,556	(198)	1,040	1,064	23
NHSE/I Top up	17,667	14,692	15,858	1,167	2,973	4,139	1,167
Total Operating Income	**114,251**	**95,319**	**96,354**	**1,035**	**19,194**	**20,419**	**1,225**
PAY	(80,987)	(67,150)	(67,070)	80	(13,567)	(13,654)	(87)
NON PAY	(32,755)	(27,516)	(27,137)	379	(5,577)	(5,380)	198
Total Operating Expenditure	**(113,742)**	**(94,666)**	**(94,207)**	**459**	**(19,144)**	**(19,034)**	**110**
Operating surplus/deficit	**509**	**653**	**2,147**	**1,494**	**50**	**1,385**	**1,335**
NET FINANCE COSTS	(2,221)	(1,851)	(1,467)	384	(370)	24	394
Retained Surplus/Deficit	**(1,712)**	**(1,198)**	**680**	**1,878**	**(320)**	**1,409**	**1,729**
Technical Adjustments	0	0	26	26	0	(15)	(15)
Break Even Surplus/(Deficit)	**(1,712)**	**(1,198)**	**706**	**1,904**	**(320)**	**1,394**	**1,715**

3.2. The month 11 surplus (£1.394 million) is a significant improvement on the month 10 deficit (£680,000) due to a number of issues. The following table shows where the improvements have been made:

Month 10 I&E position	(680)
Run rate improvements M10-11:	
Add non NHS income (5/6X £1.4M)	1,167
Income	143
Pay	121
Non Pay	91
Net Finance Costs (PDC Dividend)	333
Depreciation	120
HEE income above exp	56
Profit on disposal	64
Technical Adjustments	(21)
Month 11 I&E position	**1,394**

3.3. The month 11 improvements in the above table have resulted in a year to date surplus of £706,000.

3.4. Assuming that the Trust's final A/L accrual is fully funded the likely position is that the Trust will now break-even at the year end and it is worth setting out the 2020/21 history of the Trust's changing forecast in the remainder of this section.

3.5. The Trust submitted a "likely" forecast deficit of £4.8 million as shown in the table below:

Previous Forecast (Month 10)	£M	Comment
Non NHS Income	(0.9)	
A/L accrual	(0.6)	
Operational issues	(0.2)	
Planned Deficit	**(1.7)**	**October 2020 Plan**
I&E improvements	**0.4**	£0.3M exp; £0.1M income
Forecast Deficit	**(1.3)**	**NHSEI submission 6th January 2021**
A/L accrual	(3.0)	total £3.6m, (£0.6m in £1.3m deficit plan)
Non NHS income	(0.5)	total £1.4m, (£0.9m in £1.3m deficit plan)
Likely Case	**(4.8)**	**NHSEI submission 27th January 2021**

3.6. The likely case of £4.8 million deficit has now changed to a break-even position as follows:

Latest Forecast (Month 11)	£M	Comment
Likely Case	**(4.8)**	**as above table**
Non NHS Income	1.4	Funding agreed and paid
A/L accrual	3.6	Final figure TBC but will be funded
CCG contract adjustment	(0.3)	as discussed at February FPI committee
FOT	**(0.0)**	**Acceptable I&E position - break-even**

3.7. NHSEI have now funded the full loss of non NHS income (£1.4 million for months 7-12) resulting in an improvement to the forecast.

3.8. NHSEI have also indicated that the A/L accrual will either be funded or be an allowable variance from break-even. This is currently £3.6 million although this will be revisited in March to confirm a final figure for the Trust.

3.9. It was previously reported that the STP had asked all providers across Cheshire and Merseyside to contribute to the aggregate CCG deficit, in order to protect the total resource available to the whole system in 2021/22. The final figure (relating to S&F CCG) is £250,000.

3.10. In conclusion the Trust is confident that the revised likely forecast of break-even can be achieved, provided the annual leave accrual is fully funded.

4. Business Unit Budget Performance

4.1. The table below provides a breakdown of Trust performance across business unit.

Business Unit	Annual	Year to Date			In Month - Month 11		
	Budget £000	Budget £000	Actual £000	Var £000	Budget £000	Actual £000	Var £000
Urgent Care	(58,729)	(53,693)	(53,047)	646	(5,218)	(5,226)	(8)
Planned Care	(56,097)	(51,289)	(50,696)	593	(4,823)	(4,621)	202
Specialist Care	(35,105)	(31,994)	(32,174)	(180)	(2,965)	(2,871)	94
Corporate	201,443	185,269	185,394	125	17,116	18,292	1,176
Finance	(6,064)	(5,649)	(5,661)	(12)	(510)	(539)	(29)
Estates & Facilities	(17,009)	(15,619)	(15,760)	(141)	(1,386)	(1,502)	(116)
Human Resources	(3,097)	(2,818)	(2,957)	(139)	(279)	(295)	(16)
Nursing & Midwifery	(3,631)	(3,310)	(3,373)	(63)	(365)	(369)	(4)
Medical Director	(8,765)	(8,020)	(7,941)	79	(744)	(742)	2
Strategy	(9,626)	(9,394)	(9,341)	53	(776)	(757)	19
Financing Costs	(5,051)	(4,681)	(3,738)	943	(370)	24	394
Total	**(1,731)**	**(1,198)**	**706**	**1,904**	**(320)**	**1,394**	**1,715**

4.2. Planned Care underspend relates mainly to non pay as a result of the pause in the elective programme.

4.3. Specialist Care underspend relates to additional income from the Local Authority in respect of the Sexual Health Contract.

4.4. Corporate includes income in Month 11 to compensate for the reduction in non NHS income (£1.166 million M7-11).

4.5. Estates & Facilities overspend reflects the ongoing shortfall on car park income due to free staff parking as well as non pay issues such as the clinical waste contract.

4.6. Financing Costs reduced due to the following:

- Depreciation reduction following closure of the Quarter 3 asset register.
- PDC dividend reduction resulting from higher monthly cash balances as a result of the front loading of CCG contract payments.

4.7. In terms of run rate it should be noted that spend on consultants increased, most residing within General Medicine. In addition, there has been a significant increase in nursing substantive pay which is impacted by the nurse recruitment scheme.

5. Activity Performance

5.1. There was no monitoring of Trust activity during the first six months due to the financial framework in place.

5.2. The table below illustrates the increase in activity since month 4 as the Trust began to restore activity following the first wave of COVID and the impact that second/third wave COVID is

having.

Table 4 Activity and Income performance

PbR Activity & Income																									
	2019/20		2020/21																						
	Average		Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Oct-20		Nov-20		Dec-20		Jan-21		Feb-21	
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	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	946	5,355	928	4,677	835	4,575	722
DC	1,701	912	436	194	453	206	657	348	1,050	550	1,051	550	1,314	747	1,338	746	1,305	749	1,179	627	931	443	983	472
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	1,573	150	1,605	166	1,773	174
EL	175	504	32	93	41	110	44	89	91	235	111	296	124	337	174	437	163	380	134	399	90	180	68	150
NEL	2,838	5,358	1,626	2,546	2,053	3,285	2,223	3,934	2,287	4,667	2,094	4,342	2,201	4,546	1,952	3,921	2,060	4,083	2,012	4,488	1,832	3,766	1,932	3,430
OP F2F	10,196	1,151	2,275	269	2,505	311	3,767	448	5,891	680	5,989	695	7,757	898	8,076	908	7,697	893	7,120	814	6,554	757	6,558	753
OP NF2F	1,148	36	6,180	374	6,667	418	8,676	544	8,782	543	6,253	363	7,441	434	7,082	416	7,450	433	6,566	375	6,698	388	6,520	382
OPPROC	4,662	633	730	118	917	148	1,966	300	2,695	396	2,716	400	3,309	493	3,174	463	3,250	475	3,018	443	3,085	435	3,116	446
Grand Total	**29,866**	**9,939**	**15,234**	**4,255**	**17,868**	**5,343**	**23,872**	**6,692**	**28,167**	**8,202**	**25,759**	**7,813**	**30,010**	**8,649**	**29,117**	**8,032**	**29,253**	**8,137**	**26,957**	**8,224**	**25,472**	**6,971**	**25,525**	**6,529**

5.3. As expected the Trust observed a significant reduction in both elective inpatient and day case activity since January 2021 compared to 2019/20 average as a result of cancelling non-urgent elective work to assist with the management of COVID patients. Elective activity in February was only at 40% of 2019/20 average, whilst day case activity was at 58% of 2019/20 levels. This is compared to the original recovery target of 90% for both elective and day cases.

5.4. The Trust has received confirmation that the Elective Incentive Scheme (EIS) has been suspended across Cheshire and Mersey with effect from 1st October 2020 due to the high levels of COVID bed occupancy across the region. EIS will remain suspended for the remainder of the financial year as COVID numbers are predicted to remain above the 15% occupancy threshold.

5.5. Diagnostic Imaging performance is 95% in month against last year's average and this year's target for February 2021 of 90%.

5.6. Outpatient activity remains over 100% of 2020/21 levels as a result of significantly increased non-face-to-face attendances which now account for around 51% of all contacts.

5.7. A&E attendances for February continued to remain low however an increase in Non-Elective activity was observed when compared to the previous month.

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

6. Cash

6.1. The cash balance at the end of February was £22,378,000 against a forecast of £19,435,000.

6.2. Note there are some timing issues which explains why the Statement of Financial Position shows cash at a slightly higher value of £22,449,000.

6.3. There are a number of factors which explain why the cash balance was almost £3,000,000 more than forecast:

- Receipt of £1,400,000 for lost non NHS income (in March's forecast not in February).
- Other receipts circa £500,000 more than forecast.
- NHS and non NHS payment runs were approximately £1,100,000 less than forecast.

6.4. The issue with payment runs is related to a combination of a backlog of approvals together with capital spend invoices not yet being payable.

6.5. A cash flow for March and April is in the appendices and has been updated to reflect the majority of the latest issues.

6.6. However, on 15th March received an unexpected £2,198,000 (of £3.6 million) in relation to a

partial payment relating to the annual leave carry forward.

6.7. In addition the Trust has to bill out for partially completed spells which will give the Trust a further c £750,000 cash payment.

6.8. Historically, partially completed spells is provided for as an accrual but with the move to block contracts during COVID all providers have been instructed to transact through issuing invoices.

6.9. It will be a challenge to reduced cash balances to the target of £1,345,000 at the year end.

6.10. The Trust's payment configuration form has been temporarily updated so that suppliers will be paid much quicker in March to aid utilisation of cash.

6.11. Given the challenges of trying to reduce cash balances discussions have taken place with the national team around adjusting this year's External Financing Limit (EFL).

6.12. The undershoot against the Trust's EFL is forecast at approximately £5,900,000 with a year-end cash balance of £7,245,000.

6.13. An adjustment will be requested in the Trust's draft accounts to mitigate this undershoot.

6.14. This gives a cash cushion into April and means there is enough cash for payment runs until the next contract payments on 8th April.

6.15. Previously the Trust had expected 2 block payments in April, similar to the arrangement in 2020/21. However, it has now been confirmed that April's block will be paid on 8th April and May's on 15th May.

6.16. Cashflows have been updated to reflect all the changes above.

7. Debtors

7.1. Overall debt has increased from £5.9 million last month to £6.1 million this month.

7.2. The debt increase is entirely NHS related.

7.3. Note the Sefton Council invoice for £1,573,000 highlighted last month was paid on 3rd March so it is expected that overall debt will reduce in March.

7.4. An analysis by customer type is shown in the appendices.

8. System Financial Position

8.1. With funding of annual leave and non-nhs income the system is overall £6.2m in deficit, with increasing optimism of this further improving to near breakeven, although a number of Trusts are still showing material deficits.

9. Forecast Outturn

9.1. The Trust submitted plans for a £1.7 million deficit for the second half of the year (H2) following discussions with NHSEI and Cheshire & Merseyside Health & Care Partnership (HCP).

9.2. There have been a number of iterations to the forecast following discussions at national level.

9.3. The non NHS Income shortfall (£1.4 million) has now been funded.

9.4. The Trust also agreed to contribute to the CCG break-even exercise (£250,000). It is expected that this can be mitigated.

9.5. The Trust's current forecast for the cost of the A/L accrual remains at £3.6 million. The final figure for the annual leave accrual will not be known until after 31st March when all leave is known and reported through the ESR system.

9.6. Due to the funding of non NHS income and the assumed full funding of the A/L accrual the Trust is forecasting a break-even position.

10. Financial Planning 2021/22

10.1. Information relating to the 2021/22 financial plan is emerging as this report is being prepared, however we do know some of the key issues that we will need to deal with:

10.2. Broadly funding allocations are expected to be based on 2020/21 Q3 expenditure, being the point where Covid was at its most stable, effectively as now. There are a number of adjustments to this which include an efficiency requirement of 1.6% of which 0.8% is expected to be delivered in the first half year. The allocation is fixed and we will be expected to live within it.

10.3. Pay inflation has been excluded (expect a small number of 2 year agreements) and will be separately funded once agreed with pay review bodies.

10.4. The indicated funding includes Covid monies, compensation of lost staff car parking income and other sources of income as they recover (e.g. retail). Covid monies are subject to system allocation and could be subject to change.

10.5. Restoration funding is excluded. Access to the national £1bn elective recovery fund (ERF) will on a system basis and will trigger tariff payments once elective and outpatient activity is restored above specified levels; starting at 70% of 2019/20 levels in April. Activity above these levels and up to 85% of 2019/20 levels will paid at tariff and above 85% of 2019/20 levels, at 120% of tariff.

10.6. Whilst an indicative financial plan was considered at FP&I, it was agreed to note the work done to date and refresh this with once all the information becomes available for consideration at April FP&I and then subsequent approval at May Board. In the meantime, existing budgets will effectively be rolled over.

11. Recommendation

11.1. The Board is asked to note that:

- that the Trust is on target to achieve the year end break-even plan, assuming full funding of the annual leave accrual and barring any material unexpected events; and
- the recently/currently being released information relating to 2021/22 financial planning will be incorporated into a Trust financial plan that will be considered by FP&I at its April meeting and Board at its May meeting. In the meantime existing budgets will be effectively rolled over.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP	WORKFORCE COMMITTEE
MEETING DATE:	30 MARCH 2021
LEAD:	PAULINE GIBSON

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Personal Development Reviews
PDR compliance has decreased from 70.4% in January 2021 to 69.5% in February 2021, which has further increased the gap of meeting the 90% target. Focus is currently placed on developing a clear action plan utilising the outcomes of the deep dive, to be presented to Committee in April. This remains an area of concern.

Sickness Absence
Sickness absence hit a peak in February with 373 staff absent. The Trust has been including those shielding in its sickness figures which has now been amended to align with other Trusts. This should impact the reported figures next month – it accounts for 48% of covid-related absence. We still have the highest sickness levels in the region at around 10% (STHK 8%, LUFT 7.75%). Of particular concern was the evident reduction in sickness which coincided with the return of schools. From 15th March each CBU will have a dedicated HR advisor supporting and each CBU has committed to provide a plan and proposed trajectory for reduction of sickness absence.

ADVISE

Recruitment and Temporary Staffing
A number of important points pertaining to recruitment: the international recruitment programme has been going well and the Trust are looking to extend this to recruiting international medical staff; Time to Hire has increased only slightly which is an achievement based on their current activity; 31 Healthcare Assistant offers were made at a recent recruitment event; the nursing incentive scheme has helped increased bank fill. Agency spend for medical and nursing has reduced by utilising NHSP and Patchwork.

E-Rostering and E-Job Planning
NHSi have extended completion of Levels of Attainment from April to September due to the impact of Covid. The Trust has attained 96% Level Two of clinical staff with level 3 standards in place in some areas. 85% of all staff have joined the roster. There are issues with the pace of job planning, including with the Non-Medical staff, who also need job plans. A lessons learnt will be produced in time for next year's round of job planning.

Staff Survey
Highlights include: above the national average for Health and Wellbeing, Equality, Diversity and Inclusion and quality of care. Staff engagement of 6.8 is below sector average 7.0. Improvements can also be sought in recommending the Trust as a place to work, Perception of fairness and % of staff experiencing harassment, bullying or abuse. A national quarterly survey will be released, which will act as a pulse survey, to give more up-to-date results. Focussed action plans will be undertaken at CBU level to make further improvements in areas and to ensure learning is disseminated and cultural improvements reinforced.

ASSURE	
Safe Nurse Staffing For the month of February 2021, the Trust reports safe staffing against the national average (90%) at 92.87%, above the national target. Leads and operational Matrons were commended for their daily focus on safe staffing. **Apprenticeships** Apprenticeship levy funds began to expire in Nov 2020. Whilst Covid has impacted on registrations in Q3/4 current apprentices remain on programme. New registrations in the pipeline for further Registered Nurse Degree apprenticeships in quarter 4 and there is continued engagement with HEE and partner providers as the new standards become available. The Committee congratulated the work on Apprenticeships and the consistent good news story that brings ongoing assurance. **Staff Story** The Committee were presented with a story from Ajl Anto Chalissery, an international nurse, who shared their experience of initial recruitment to eventually working in the organisation. Their story highlighted they had received a good and caring experience of the process. The Committee thought Ajl's story was extremely uplifting and emotive but noted how the Trust may need to do some more work on educating the nurses about the organisation at the point of initial engagement. The Chair requested this story be presented to the Board.	
New Risk identified at the meeting	None.
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	

Workforce

Agency

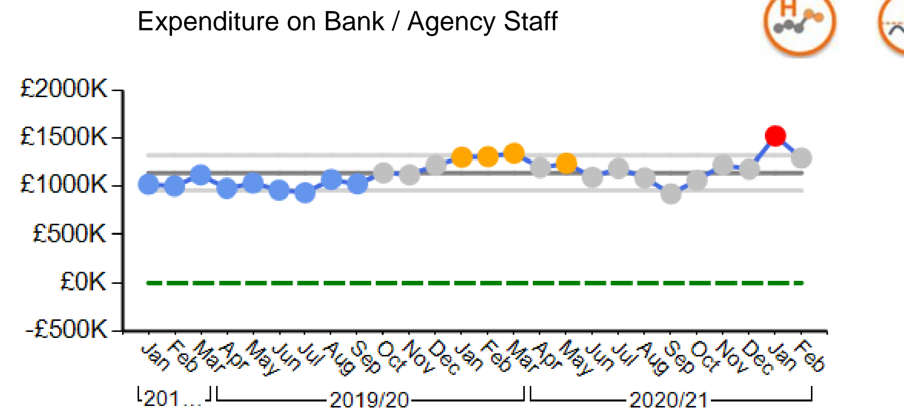
Analyst narrative:

The Expenditure on Bank / Agency Staff is failing assurance and showing special cause concern but there has been a reduction in February.

Operational Narrative:

A reduction in bank and agency spend forecasted due to the catch up of the nurse incentive scheme payment made in January.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Expenditure on Bank / Agency Staff	£00K	£1,294K	N/A	Feb 21		£00K	£1,524K	Jan 21		£13,010K	



Workforce

Organisational Development

Analyst Narrative:

Personal Development Reviews is the only indicator failing its assurance measure and there has been a marginal decline in performance in February. Mandatory training continues to be assured, with performance ahead of plan. This needs to be sustained. The national Staff Friends & Family Test continues to be suspended but the Staff - % That Would Recommend as a Place to Work has been updated from the Staff Survey undertaken in Autumn 2020.

Operational Narrative:

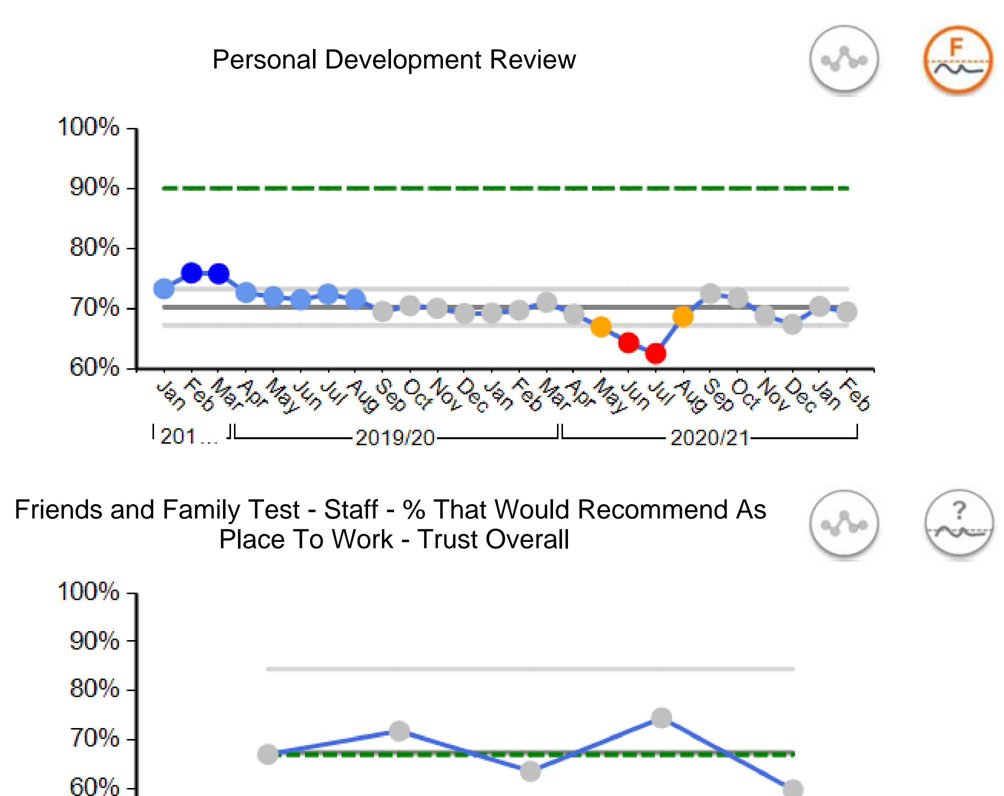
PDR completion rate continues to be an area of concern and has been affected by the demands placed on the workforce due to covid. CBU PIDAs have now been reinstated to monitor progress against the CBU improvement trajectory, which will also help drive uptake of PDRs going forward. In order to drive more sustainable change and improvement, several activities have recently been undertaken to understand the PDR approach in greater detail including a deep dive and an MIAA. These resulted in a series of organisational recommendations, some of which were consistent in view. A draft action plan is in development, which will include key deliverables and timeframes for delivery. The immediate priority actions relate to review of the process for recording PDRs. Also refer to action plan for PDR's.

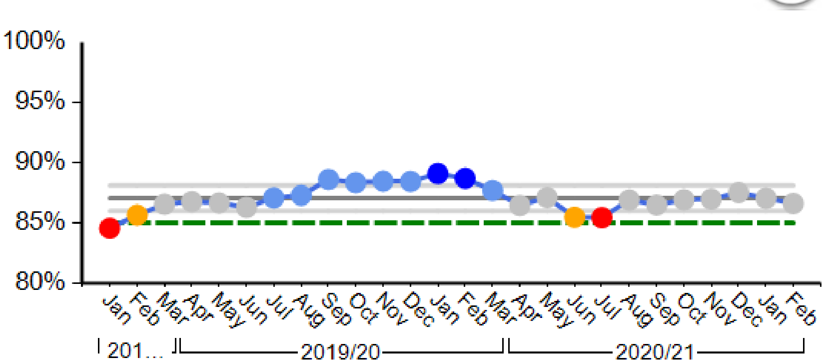
Staff recommendation of the Trust as a place to work has declined since March 2020. It has been consistently lower than the national average for the past five years and is now 7.1% lower. 2020 has not been "business as usual" for the workforce and the impact of the COVID-19 pandemic has had a profound impact across the NHS.

It is important to acknowledge the change journey this Trust has recently embarked upon and take into consideration that it may take a couple of years before improvements become apparent in the survey results. The 'What Next' in terms of responding to the employee voice is of paramount importance in helping to drive and measure this change. Key next steps include:

- At an organisational level, acknowledge the areas where staff survey findings indicate a positive difference is being made to people's experience at work to further embed good practice and continue to take proactive steps in creating a great place to work.
- Actions arising from the staff survey which have an impact on staff from protected groups will be considered and actions built into other mechanisms and frameworks such as equality action plans.
- Going forward, leaders across the Trust need to drive engagement within their areas and will be encouraged to hold meaningful engagement with staff throughout the year to promote open and honest conversations, gain staff trust and work on co-designing changes. Assurance will be provided through appropriate channels of governance that they are driving forward the changes collaboratively within their CBU/teams.
- At an organisational level, responding to the employee voice and being open and honest in our communications indicates that our colleagues are a valued and integral part of the organisation and its improvement journey.
- The HR and Organisational Development teams will work with all levels of the Trust to respond to the feedback received this year.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Personal Development Review	90%	69.5%	N/A	Feb 21		90%	70.4%	Jan 21	90%	69.1%	F
Mandatory Training	85%	86.6%	N/A	Feb 21		85%	87.1%	Jan 21	85%	86.6%	P
Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall	67%	59.8%	N/A	Dec 20		67%	74.5%	Mar 20	67%	59.8%	?


Personal Development Review
100%
90%
80%
70%
60%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2019/20
2020/21
Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall
100%
90%
80%
70%
60%
50%
Jan
Apr
Jul
Mar
Dec
2018/19
2019/20
2020/21


Mandatory Training
100%
95%
90%
85%
80%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2019/20
2020/21

Workforce

Sickness, Vacancy and Turnover

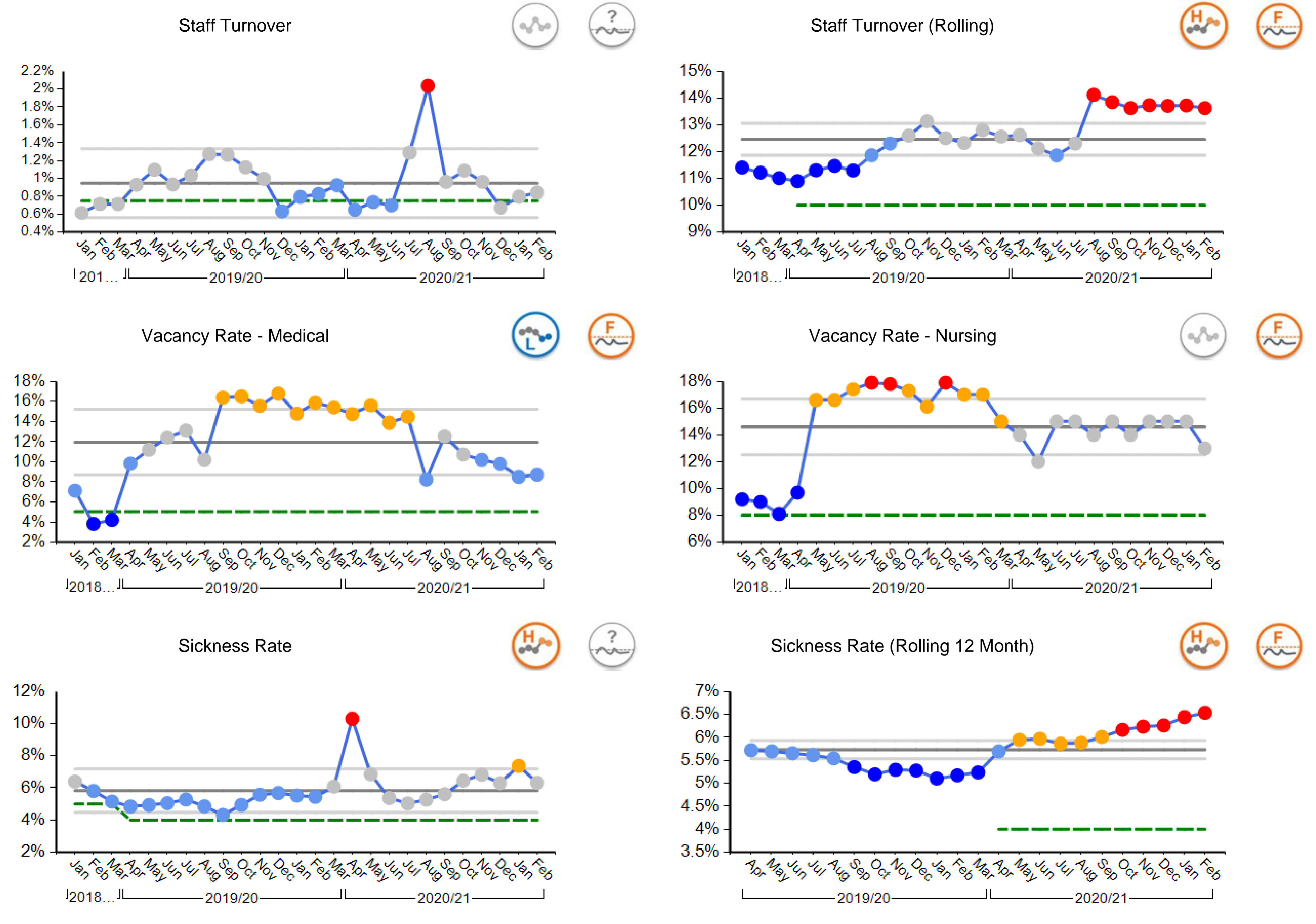
Analyst Narrative:

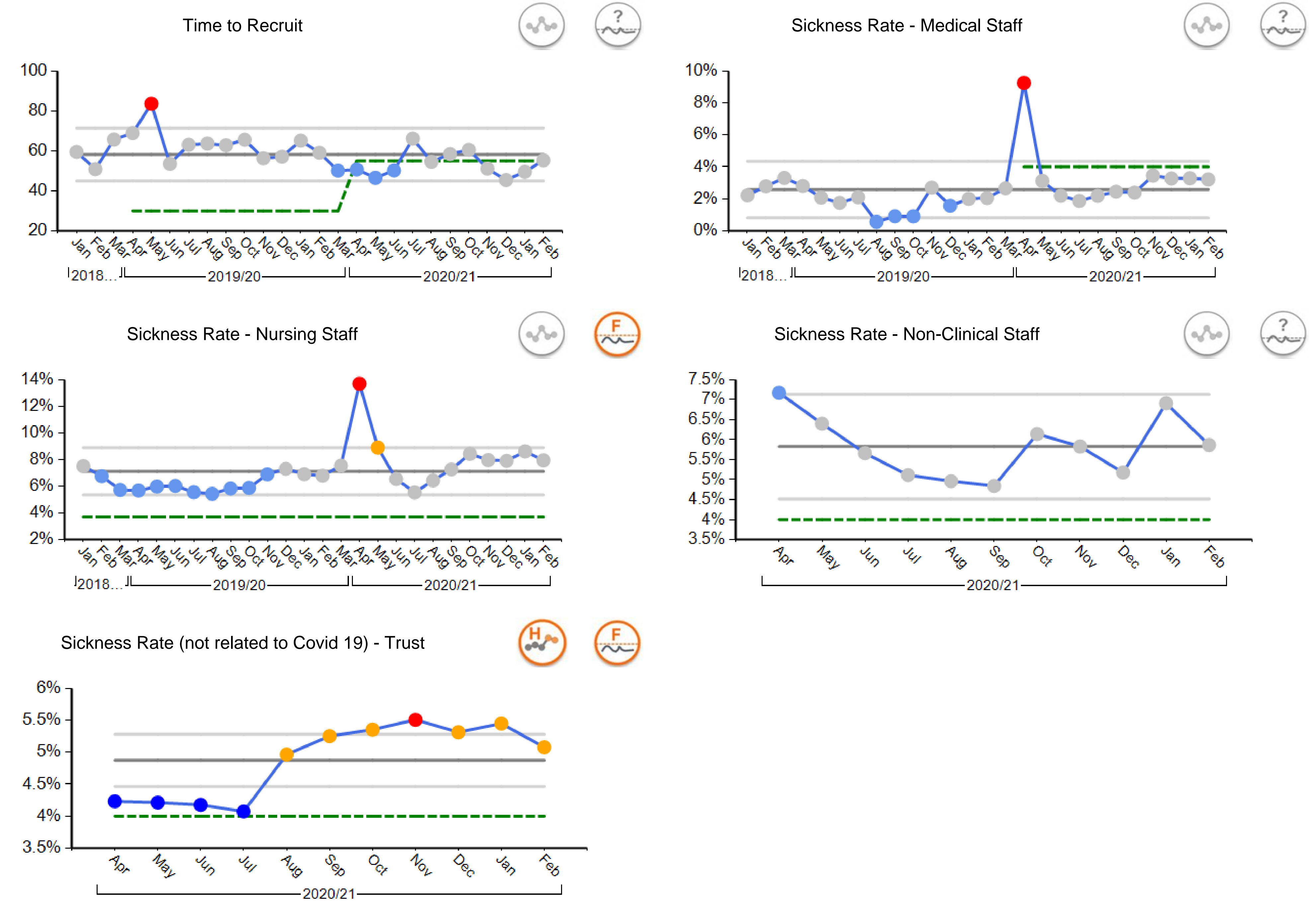
Several indicators are currently failing to provide assurance, relating to sickness, turnover and vacancy rates, although sickness rates across all staff groups have reduced in February. A reduction in vacancy rates is evident within nursing, as the effect of the international recruitment takes effect; vacancy rates within this cohort are now at their lowest point since May 2020. In month turnover is in line with the plan, but the rolling position continues to be impacted by the spike in August 2020.

Operational Narrative:

Sickness absence is the main priority as it remains high, particularly in comparison to other Trusts in the region.
There was of peak of sickness absence in early February 2021 with 373 staff were absent. More recently there has been a sudden reduction in absence, so as at 9th March 2021, there are 311 staff absent due to sickness related issues. This recent reduction in absence coincides with the reopening of schools.
Despite the recent reduction, the Trust sits amongst other Trusts in the region with the highest sickness absence.
Covid related absence continues to be high for the Trust and is most prevalent in Planned Care and Estates & Facilities, and amongst nursing and midwifery staff. A recent review into the reporting of covid-related absence has revealed that other Trusts do not report on shielding employees amongst their covid related absence figures. As this group make up 48% of covid-related absences, the recent removal of them from the figures brings the Trust's covid absence rates more in line with other Trusts.
As at 9th March 2021, the majority of non-covid related absence continues to be long term and this is reflected at CBU level too, although Estates and Facilities has a higher proportion of long term absence. The main causes for long term non-covid absences currently relate to 'Anxiety, stress etc', 'Musculoskeletal' and 'Unknown' reasons.
Short term absences have also been increasing over this reference period, particularly in Specialist Services. There are varying reasons for short term absences across the Trust.
A joint Trust-wide communication was released in February 2021 explaining the localised Social Partnership Agreement approach going forward. In addition, the HR Advisory Service has been launched and from 15th March 2021, each CBU (including Estates & Facilities) will have a dedicated HR Advisor supporting the management of absence going forward.
Anecdotal feedback on what is causing staff to be absent from work suggests that additional support may need to be considered to ensure staff do not feel they have to resort to taking sick leave. For example, some staff have had to deal with multiple bereavements and the special leave policy does not provide for these situations. The reduction in absence coinciding with children returning to school possibly indicates a weakness in our carer's leave and flexible working policy.
A series of actions have been agreed to reduce absence further, including a commitment of each CBU to provide a plan and proposed trajectory of absence reduction against its current pool of long term and persistent short term absentees. See also supplementary action plan.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Turnover	0.75%	0.8%	N/A	Feb 21		0.8%	0.8%	Jan 21	9%	6.8%	?
Staff Turnover (Rolling)	10%	13.6%	N/A	Feb 21	H	10%	13.7%	Jan 21			F
Vacancy Rate - Medical	5%	8.7%	N/A	Feb 21	L	5%	8.5%	Jan 21	5%		F
Vacancy Rate - Nursing	8%	13%	N/A	Feb 21		8%	15%	Jan 21	8%		F
Sickness Rate	4%	6.3%	N/A	Feb 21	H	4%	7.4%	Jan 21	5%	6.5%	?
Sickness Rate (Rolling 12 Month)	4%	6.5%	N/A	Feb 21	H	4%	6.4%	Jan 21	4%	6.1%	F
Time to Recruit	55	55	N/A	Feb 21		55	50	Jan 21	55	54	?
Sickness Rate - Medical Staff	4%	3.2%	N/A	Feb 21		4%	3.3%	Jan 21	4%	3.3%	?
Sickness Rate - Nursing Staff	3.7%	8%	N/A	Feb 21		3.7%	8.6%	Jan 21	3.7%	8.1%	F
Sickness Rate - Non-Clinical Staff	4%	5.9%	N/A	Feb 21		4%	6.9%	Jan 21	4%	5.8%	?
Sickness Rate (not related to Covid 19) - Trust	4%	5.1%	N/A	Feb 21	H	4%	5.4%	Jan 21	4%	4.9%	F


Staff Turnover
2.2%
2%
1.8%
1.6%
1.4%
1.2%
1%
0.8%
0.6%
0.4%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2019/20
2020/21
Staff Turnover (Rolling)
15%
14%
13%
12%
11%
10%
9%
2018...
2019/20
2020/21
Vacancy Rate - Medical
18%
16%
14%
12%
10%
8%
6%
4%
2%
2018...
2019/20
2020/21
Vacancy Rate - Nursing
18%
16%
14%
12%
10%
8%
6%
2018...
2019/20
2020/21
Sickness Rate
12%
10%
8%
6%
4%
2%
2018...
2019/20
2020/21
Sickness Rate (Rolling 12 Month)
7%
6.5%
6%
5.5%
5%
4.5%
4%
3.5%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019/20
2020/21



Time to Recruit
100
80
60
40
20
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Sickness Rate - Medical Staff
10%
8%
6%
4%
2%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Sickness Rate - Nursing Staff
F
14%
12%
10%
8%
6%
4%
2%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2018...
2019/20
2020/21
Sickness Rate - Non-Clinical Staff
7.5%
7%
6.5%
6%
5.5%
5%
4.5%
4%
3.5%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
Sickness Rate (not related to Covid 19) - Trust
H
F
6%
5.5%
5%
4.5%
4%
3.5%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21

Title Of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB051/21	FOI Exempt	NO
Report Title	ANNUAL STAFF SURVEY UPDATE		
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Sonya Clarkson, Deputy Director of HR and OD		
Action Required	☐ To Approve ☐ To Assure	✓ To Note ✓ To Receive	

Purpose

To provide an update regarding the findings of the 2020 NHS Annual Staff Survey.

Executive Summary

This report provides the Board of Directors with a high-level overview of the results from the 2020 NHS Annual Staff Survey. The Trust's current position in relation to the 10 themes of the staff survey is detailed, how it compares to last year as well as to the sector and national averages. Where we are doing well, and not so well, provides more of a sense of what is important to our staff, as well as providing the foundation to build on current successes and make improvements.

The 'What Next' in terms of responding to the employee voice is of paramount importance. We all want Southport and Ormskirk to be a great place to work and receive treatment and it is this co design of the shaping of the future which is integral to the employee voice being heard. Engaging with our staff in a meaningful and impactful way is how we will make them feel valued, listened to and more importantly part of the S&O family. The recently re-instated Valuing Our People Inclusion group will play a key role in overseeing the progress against the priorities identified through this year's staff survey and use the (soon to be introduced) quarterly staff surveys to measure impact.

Recommendation

The Board / Committee is asked **to receive and note** the report

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	Presented By:
Cheryl Clarke, OD Manager	Jane Royds, Director of HR and OD

Annual NHS Staff Survey 2020

1. Background

The Annual NHS Staff Survey provides an opportunity to survey staff in a consistent and systematic way, making it possible to build up a picture of staff experience. Obtaining feedback from staff and taking account of their views is vital for driving real service improvements within the Trust. 2020 has not been 'business as usual' for the NHS and it remains vital that we understand the unique impact on NHS staff experience during the COVID-19 pandemic.

Obtaining staff views will enable a deeper understanding of different experiences of staff, the impact of the pandemic and how we can use this information to support staff moving forwards. Additionally, it will provide further support to the 'Looking after our people' part of the NHS People Plan 2020/21.

Listening and then responding to staff views is key so that we can not only continue to support our staff in a meaningful and compassionate way but also work alongside them to co-design the overall improvement journey for individual CBU's as well as a Trust as whole. Understanding the results at Trust, CBU, team and individual level enables different levels of action and contribution to changes to be taken.

By working together and supporting each other, we can all contribute to making Southport and Ormskirk a great place to work and receive treatment.

2. Survey Approach

In previous years the survey had been postal, however, this year the survey was a mixed mode approach with online surveys emailed out to the majority of staff via Quality Health with the exception of Capital and Facilities staff and those who did not have an email address in ESR – these staff received hard copies. This provided an opportunity to try out a different method of data collection as well as realising cost savings.

Adopting a mixed mode method of data collection (with majority being online) enabled more meaningful engagement and communication as time was freed up to focus on engaging staff in the importance of the staff voice.

A targeted engagement approach was undertaken within Capital and Facilities and this yielded an excellent survey response rate (71%).

Another change from previous years was that Capital and Facilities directorate information was recorded separately to Corporate meaning that we have response rates within 5 distinct area for 2020.

Surveys were desptached w/c 28th September 2020 and the close of the fieldwork was Friday 27th November 2020. Any completed questionnaires received online or postally on this date were included in the final submission.

Quality Health submitted the offical final data set to the National Co-ordination Centre on Friday 4th December 2020.

3. Highlights

3.1 What's going well

- 45% response rate which is in line with the sector average (79% was the best with 28% as the worst) – this is a slight reduction from 2019 response rate of 47%
- Corporate had the highest response rate at 73% (Corporate response rate for 2019 was 60%)
- Staff Survey findings are clustered into 10 themes and whilst there has been no significant variation across the themes, marginally, three were significantly better than the benchmarking sector ('health and wellbeing', 'equality, diversity and inclusion' and 'quality of care'), and 'equality, diversity and inclusion' and 'health and wellbeing' were higher than the national average.
- Staff are satisfied with the quality of care they give to patients/service users and this has improved consistently over the past three years (89% of staff feel that their role made a diference to patients/service users).
- There was also an improvement for the WRES figures relating to the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public. This has decreased in the last 12 months, and is comparable with the percentage for white staff.

3.2 What could be better

- Staff engagement score was 6.8, which is below the sector average of 7.0
- The engagement score is measured across three themes – 'advocacy', 'motivation' and 'involvement'. Whilst there has been no significant difference in the scores for the past couple of years, the 'advocacy' score is below the average for the sector. ('Advocacy' is measured by answers to questions regarding staff recommendation to work and receive treatment).
- Our happiness with the standard of care provided should a friend/relative need treatment is significantly less than the average for similar organisations, although there has been an improvement compared to last year.
- Staff recommending 'the Trust as a place to work' is 7.1% lower than the national average and has been consistently lower for the past five years, although there has been an improvement compared to last year.
- Satisfaction with senior managers and immediate managers (communication, engagement and involvement)
- Perceptions of fairness when errors, near misses or incidents happen, giving feedback and taking action (significantly lower than the sector average although it has improved from last year)
- Increase in percentages of staff (WRES/WDES/white) experiencing harassment, bullying or abuse from colleagues within last 12 months has increased from 2019.

4. Response rates for 2020

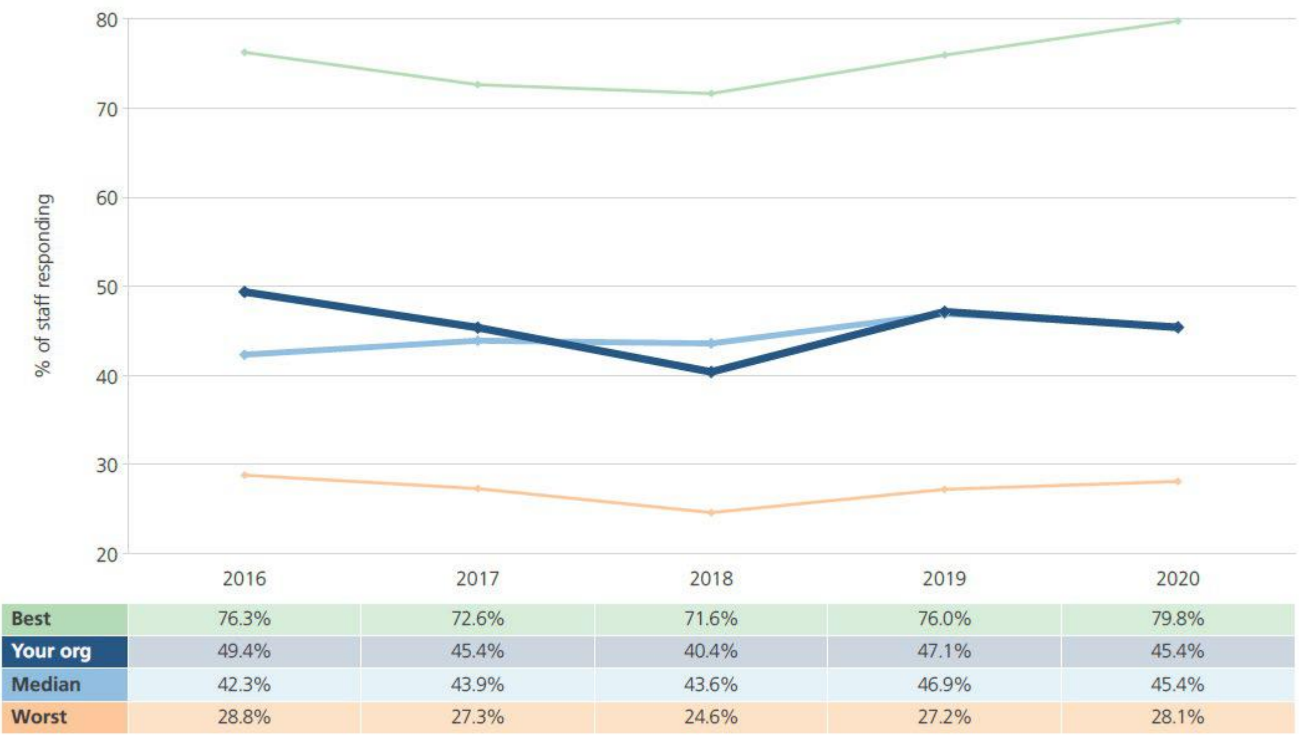
4.1 Overall response rate

Questionnaires were sent to 3,129 staff within the organization. After excluding respondents that were later known to be ineligible, a usable sample of 3,111 remained.

From the usable sample, 1412 questionnaires were returned yielding a response rate of **45%.**

Overall response rates for 2016 to 2020 are shown in table 1 below:

TABLE 1



	2016	2017	2018	2019	2020
Best	76.3%	72.6%	71.6%	76.0%	79.8%
Your org	49.4%	45.4%	40.4%	47.1%	45.4%
Median	42.3%	43.9%	43.6%	46.9%	45.4%
Worst	28.8%	27.3%	24.6%	27.2%	28.1%

There is a slight decline in response rate from 2019 of 1.7%. Given the challenging times that our workforce has faced, this is an excellent achievement and at the higher end when compared to other Acute Trusts within the Merseyside and Cheshire region. In terms of response rates we are the highest closely followed by University Hospital Trust and Mid Cheshire who had response rates of 44%.

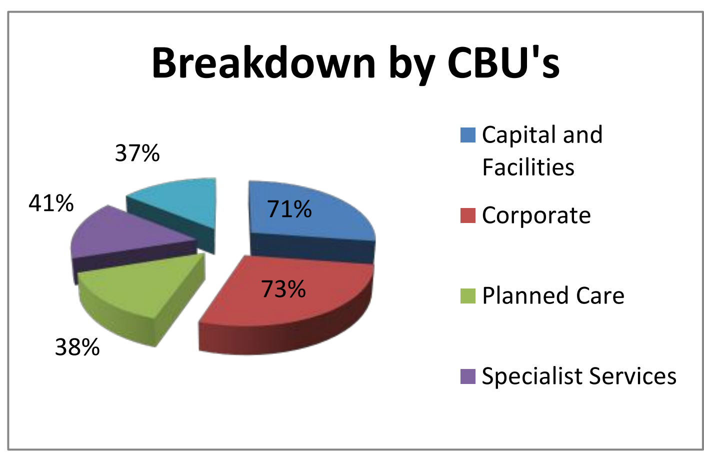
Our Trust is comparable with the median for Acute Trusts nationally.

Response rate by CBU:

A breakdown by CBU's shows Corporate has the most responses (an increase of 13% when compared to 2019 response rate), closely followed by Capital and Facilities.

Urgent Care has the lowest response rate at 37% (this is 6% less than the response rate for 2019).

All CBU's had an upward trajectory and responses increased week by week during the period that the survey was open.



5. Overview of 2020 Findings

5.1 Staff Engagement

Staff Engagement is measured across three themes:

Advocacy staff recommendation of the Trust as a place to work or receive treatment

Motivation staff motivation at work

Involvement staff ability to contribute towards improvement at work

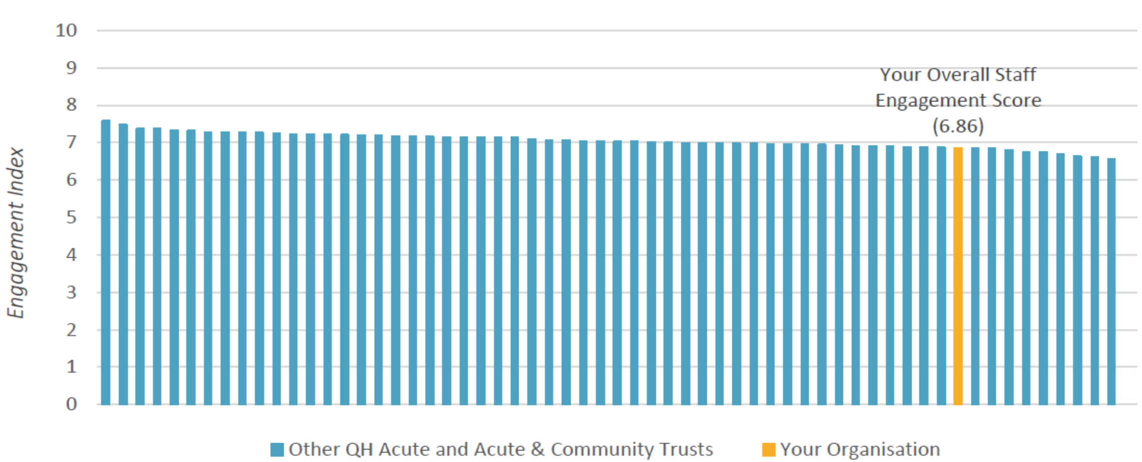
Our staff engagement score (that is, how motivated and engaged staff are at work), their happiness with the standard of care provided and whether the would recommend the Trust as a place to work **improved** but there is still work to do. Understanding what makes our staff happy and motivated, so they are fulfilled in their job, is not only good for them, but patients too.

The percentage of staff recommending the Trust as a place to work has increased nearly 5% from 2019 to 59.8% but this is 7.1% lower than the national average. Likewise staff happiness with the standard of care provided has increased just over 3% from 55.2% in 2019 to 58.4% in 2020. However, this figure is still 15.9% below the national average.

Overall staff engagement is measured as an average across these three themes. Staff engagement scores fall between 0 and 10, where the higher the score, the more engaged staff are.

In the chart below is the range of overall staff engagement scores across the Acute and Acute & Community Sector (61 organisations within the Quality Health database), shown in ranking order. The score for the Trust is 6.86 and its position within the sector is marked in orange in Table 2 below.

TABLE 2



Over the past 5 years (2016 – 2020) the staff engagement score has been between 6.6 and 6.8 – which is indicated in the Table 3 below (slightly below the sector average of 7.0) :

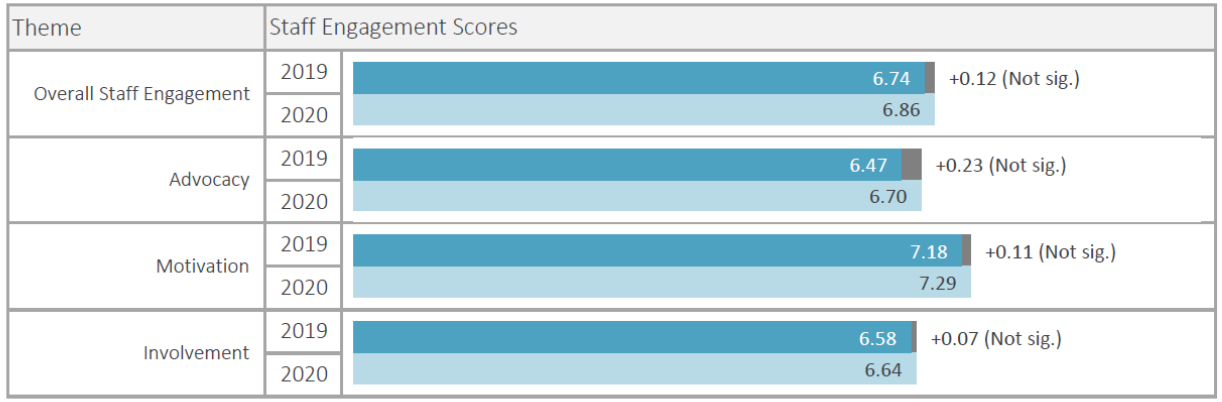
TABLE 3

	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
Your org	6.7	6.6	6.6	6.7	6.8
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.4	6.4	6.1	6.4
Responses	1,635	1,258	1,129	1,365	1,406

- **Staff engagement themes**

  In Table 4 below are the engagement scores for each of the themes that comprise overall staff engagement. Engagement scores for 2019 are also there for comparison – across the three themes there has been no significant difference between the last two years but showing a slight increase since last year.

TABLE 4



Theme	Staff Engagement Scores		
Overall Staff Engagement	2019	6.74	+0.12 (Not sig.)
	2020	6.86	
Advocacy	2019	6.47	+0.23 (Not sig.)
	2020	6.70	
Motivation	2019	7.18	+0.11 (Not sig.)
	2020	7.29	
Involvement	2019	6.58	+0.07 (Not sig.)
	2020	6.64	

5.2 Theme Results

Staff Survey findings are clustered into 10 themes and can be considered as summary scores for groups of questions which, when taken together give more information about a particular area. Themes are presented as scale scores.

The Trust has scored the same as the national average in four of the themes: morale, quality of care, safe environment – bullying and harassment, safe environment – violence.

The Trust scored higher than the national average in two of the themes: equality, diversity & inclusion and health and wellbeing.

The Trust scored lower than average in four of the themes: immediate managers, safety culture, staff engagement and team working. See Table 5 below:

TABLE 5

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.2	6.3	6.7	6.2	7.5	8.1	9.5	6.5	6.8	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,395	1,400	1,403	1,398	1,148	1,390	1,383	1,399	1,406	1,380

Although there is no significant change to theme scores since 2019, all have improved and three themes are signficantly better: health & wellbeing, safe environment – violence and safety culture (Ref Table 6).

TABLE 6

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.1**	1353	**9.2**	1395	Not significant
Health & wellbeing	**6.1**	1360	**6.3**	1400	↑
Immediate managers †	**6.6**	1363	**6.7**	1403	Not significant
Morale	**6.0**	1335	**6.2**	1398	Not significant
Quality of care	**7.4**	1150	**7.5**	1148	Not significant
Safe environment - Bullying & harassment	**8.0**	1339	**8.1**	1390	Not significant
Safe environment - Violence	**9.3**	1344	**9.5**	1383	↑
Safety culture	**6.4**	1348	**6.5**	1399	↑
Staff engagement	**6.7**	1365	**6.8**	1406	Not significant
Team working	**6.2**	1350	**6.3**	1380	Not significant

Health and wellbeing has inevitably taken its toll on many NHS staff and has pushed health and wellbeing to the top of the agenda. Nationally there has been a 4.1 percentage increase in staff feeling that their organisation takes positive action on health and wellbeing. Within this Trust there was nearly a 5% increase from last year (from 29% to 34.9%).

Although we have improved in the theme of safety culture overall, perceptions of treating staff fairly when errors, incidents or near misses happen, giving feedback and taking action are below the sector average as well as feeling secure to raise concerns and confidence in the organisation acting on concerns.

When the themes are ranked in order (with 1 being the highest scoring and 10 being the lowest scoring), 'safe environment – violence' was the highest ranked theme with 'morale' being the lowest (Ref Table 7).

TABLE 7

Rank	Theme	Description	Score
1	Theme 7	Safe Environment - Violence	9.52
2	Theme 1	Equality, Diversity and inclusion	9.27
3	Theme 6	Safe Environment - Bullying and harassment	8.09
4	Theme 5	Quality of care	7.86
5	Theme 9	Staff engagement	6.86
6	Theme 3	Immediate managers	6.75
7	Theme 8	Safety culture	6.54
8	Theme 2	Health and wellbeing	6.34
9	Theme 10	Team working	6.32
10	Theme 4	Morale	6.20

6. Workforce Race Equality Standard (WRES)

- A decrease in the gap between BME staff and white staff experiencing harassment, bullying or abuse from patients, relatives or service users in the last 12 months (4.4% in 2019 to 0.3% in 2020);
- An increase from 2% to 5.8% in the gap between BME staff and white staff experiencing harassment, bullying or abuse from staff (both BME and white staff percentages have increased in 2020 in relation to experiencing harassment, bullying or abuse from staff);
- A decrease in the percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion (78.3% in 2019 to 71.9% in 2020) – there has been a slight increase for white staff (83.3% in 2019 to 84% in 2020);
- There has been a percentage increase of 2.6% in BME staff experiencing discrimination from managers, team leaders and colleagues.

7. **Workforce Disability Equality Standard (WDES)**

- A decrease of 7.1% in the percentage of staff with a long term disability or illness experiencing harassment, bullying or abuse from patients, relatives or services users in the last 12 months;
- An increase of 4.6% in the percentage of staff with a long term disability or illness experiencing harassment, bullying or abuse from staff;
- There has been percentages increases in staff feeling valued by the organisation for their work, adequate adjustments being made to enable them to carry out their work and staff engagement score has increased from 6.7 in 2019 to 6.9 in 2020.

8. **Importance of responding to the employee voice**

2020 has not been "business as usual" for the workforce and the impact of the COVID-19 pandemic has had a profound impact across the NHS. By measuring staff experience in a consistent way to previous years, this year's Staff Survey provides a unique opportunity to understand the impact that the COVID-19 pandemic has had on staff experience.

The majority of the theme scores for the 2020 Staff Survey for the Trust show no significant difference to the sector score for acute Trusts, and three themes are significantly better. There is no significant change to theme scores since 2019.

At question level, 12 of the scores are significantly better than the sector score and 24 are worse. However, the Trust is showing improvement, with 19 questions showing to be significantly better than last year, and only 2 that have declined significantly.

It is important to acknowledge the change journey this Trust has recently embarked upon and take into consideration that it may take a couple of years before improvements become apparent in the survey results.

Actions already in place or planned which will help to address survey outcomes

- Workforce and OD Strategy - delivering the NHS People Plan
- Improved visibility of the Senior Leadership Team
- New Communications & Engagement Strategy
- Improved reward & recongition measures
- Focus on Health & Safety measures throughout the Covid pandemic
- Launch of our Staff Charter
- Embedding our SCOPE values and behavioural framework
- Review of the current appraisal system – quality & process
- Increased Leadership and Management Development through our apprenticeship offer
- Coaching provision (one to one, team coaching and online coaching modules)
- Creating a wellbeing culture (e.g. health and wellbeing offer, wellbeing guardians/champions)
- Promotion of CPD across our clinical workforce
- New Medical Leadership Development Programme
- Staff inclusion networks
- Staff engagement activities – the Big Brew
- Reshaping of the new starter experience
- SONASS Ward Accreditation Scheme

9. What Next?

Continuous drive and investment around staff engagement is critical to help ensure that staff are engaged in their work and that of the Trust. Lack of or poor engagement negatively impacts on morale, performance, patient experience and the pursuit of the achievement of excellent patient care.

At an organisational level, it is important to acknowledge the areas where staff survey findings indicate a positive difference is being made to people's experience at work to further embed good practice and continue to take proactive steps in creating a great place to work.

Actions arising from the staff survey which have an impact on staff from protected groups will be considered and actions built into other mechanisms and frameworks such as equality action plans.

Going forward, leaders across the Trust need to drive engagement within their areas and will be encouraged to hold meaningful engagement with staff throughout the year to promote open and honest conversations, gain staff trust and work on co-designing changes. Assurance will be provided through appropriate channels of governance that they are driving forward the changes collaboratively within their CBU/teams.

At an organisational level, responding to the employee voice and being open and honest in our communications indicates that our colleagues are a valued and integral part of the organisation and its improvement journey.

The HR and Organisational Development teams will work with all levels of the Trust to respond to the feedback received this year using the following principles:

- Appreciative inquiry – build on positives
- Shared ownership of actions across the organisation at organisational / management / individual level
- Building on what we have already
- Openness, transparency, feedback – sharing results on an organisational and CBU level
- Developmental and ongoing actions

The 'What Next' in terms of responding to the employee voice is of paramount importance in helping to drive and measure this change. We all want Southport and Ormskirk to be a great place to work and receive treatment and it is this co design of the shaping of the future which is integral to the employee voice being heard. Engaging with our staff in a meaningful and impactful way is how we will make them feel valued, listened to and more importantly part of the S&O family.

The recently re-instated Valuing Our People Inclusion group will play a key role in overseeing the progress against the priorities identified through this year's staff survey and use the (soon to be introduced) quarterly staff surveys to measure impact.

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB052/21	FOI Exempt	NO
Report Title	BOARD ASSURANCE FRAMEWORK (BAF)		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	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
The BAF provides a structure and 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, and the level and effectiveness of assurance provided by and through those controls. Since the last update on the Board Assurance Framework (BAF) to Trust Board, a review was undertaken with executive director leads ensuring that there was a clear updated position and that all actions were progressing in line with agreed timelines. This iteration of the BAF, has been presented to respective assurance committees and will also be presented at the next Audit Committee in April. At the end of March 2021, there has been an improvement in the current risk score for SO3 following a review and reprofiling of new actions to fit in with the programmes of work. The reduction in Likelihood to 3 means the risk is now recorded as a High risk on the risk matrix.
Recommendations
The Board is asked to **receive** the 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:
Simon Regan, Deputy Director of Deputy Director of Quality, Risk and Assurance	Sharon Katema, Associate Director of Corporate Governance

BOARD ASSURANCE OVERVIEW (UPDATED 31 MARCH 2021)

Strategic Objective	Principal Risk	Risk Appetite	Inherent Risk	Current Risk Score	Target Risk Score	Lead Committee	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**	**12**	**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	

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

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 31/03/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	3	4	**12**	2	4	**8**

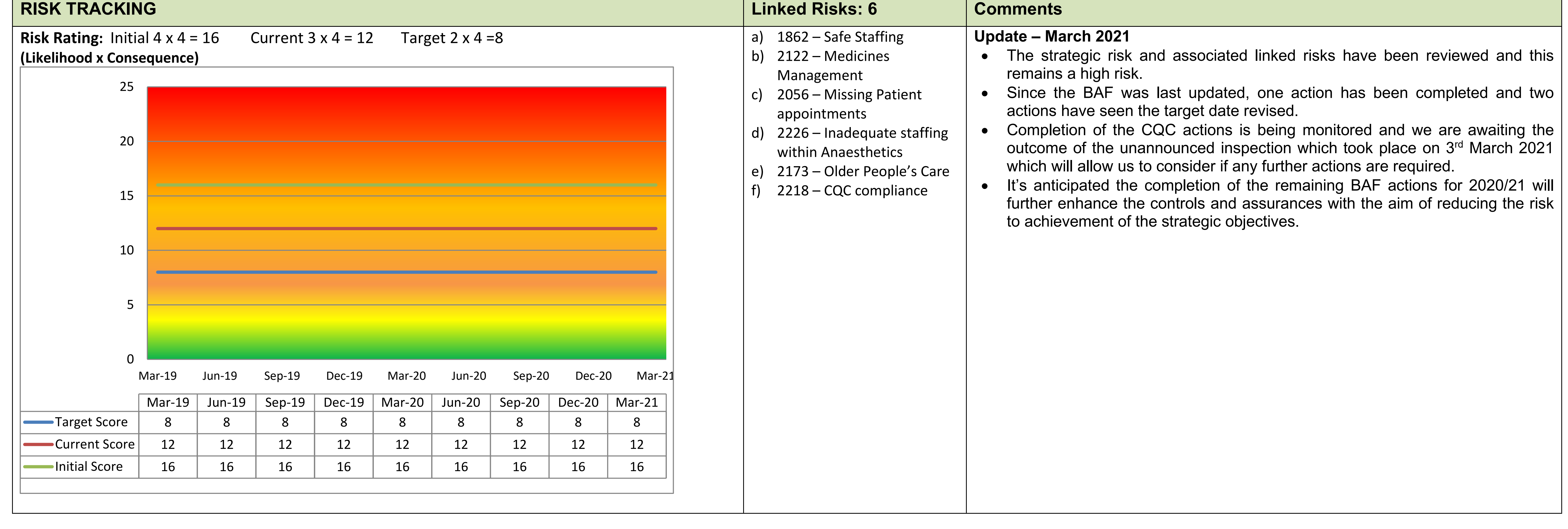
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management 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: 4. Care of the deteriorating patient; 5. Care of Older People; 6. Infection Prevention and Control; 7. Medicines Management. 8. Risk Management Strategy. 9. Risk Management training. 10. Quality impact assessments (QIAs) for all service changes that are considered. 11. Single accountability framework for reviewing CBU areas for development/strengths. 12. KPI dashboards for wards and CBUs in place at key governance meetings. 13. Clinical audit programme /outcomes. 14. Application of clinical pathways and guidelines. 15. Programmes in place for clinical standards and professional practice. 16. Mortality and SJR Process. 17. Work plans for medical staff. 18. Clinical revalidation. 19. Ward/departments staffing position is controlled through: 20. 3 x daily at staffing huddle; 21. 7 day staffing matron in place for oversight and management; 22. Weekly staffing review and sign off; 23. Roster sign off meeting. 24. Training programme (mandatory and non-mandatory). 25. CQC action plan to address areas of underperformance highlighted on inspection. 26. Quality Visits/Senior Walkabouts including focus on Patient Safety 27. Supervision and education of clinical staff across all professions. 28. Application of Patient Safety and other safety alerts. 29. Patient Safety Specialists appointed.	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. 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 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 Assurance Framework (AF) **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SONASS ward accreditation programme 8. VitalPac deterioration measures **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits.	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.	1. Cycle of business to be reviewed for Trust-wide and CBU governance meetings. - **COMPLETED reviews and to be implemented** 2. 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** 3. Clinical workforce strategy to be completed **– by end of Dec-21.** 4. Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed. – **By end March 2021** 5. Risk management training with senior leaders in the organisation **– COMPLETE – ongoing training in place** 6. Complete CQC Must and Should Do actions – ~~By end of Jan 2021.~~ **Mar-20 Update:** The process of validation and monitoring completion of the actions has been strengthened. Whilst progress has been made, all actions aren't fully complete, some of which have been affected by COVID/other factors. Awaiting outcome of CQC unannounced inspection before updating trajectories. 7. Review KPIs that goes to all governance meetings – **By end Mar 2021.** 8. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. – ~~By end of Jan 2021.~~ **Revised to Jun-21:** The sharing of lessons learnt has been enhanced significantly but further work is planned with Clinical Audit and CBUs to test that completed actions/changes are embedded. 9. Review health and safety/fire risk assessment/audit programme – **COMPLETE** 10. Complete appointments to medical examiners roles and fully establish

	30. Cycles of business for governance meetings 31. PIDA, agreed suite of measures in place. - **COMPLETE**		3. CQC inspection visits, Insight Reports, Outlier Alerts and engagement meetings 4. Healthwatch 5. National Audits 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account		programme to review all deaths – ~~by end of Feb 2021.~~ **Revised to Jul-21:** There have been delays in implementing due to COVID-19 and delays in recruitment. 11. Appoint patient safety specialist – **COMPLETE** 12. PIDA, agreed suite of measures in place. - **COMPLETE** 13. 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

Risk Rating: Initial 4 x 4 = 16 Current 3 x 4 = 12 Target 2 x 4 =8
(Likelihood x Consequence)

	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	12
Initial Score	16	16	16	16	16	16	16	16	16

Linked Risks: 6

a) 1862 – Safe Staffing
b) 2122 – Medicines Management
c) 2056 – Missing Patient appointments
d) 2226 – Inadequate staffing within Anaesthetics
e) 2173 – Older People's Care
f) 2218 – CQC compliance

Comments

Update – March 2021

- The strategic risk and associated linked risks have been reviewed and this remains a high risk.
- Since the BAF was last updated, one action has been completed and two actions have seen the target date revised.
- Completion of the CQC actions is being monitored and we are awaiting the outcome of the unannounced inspection which took place on 3rd March 2021 which will allow us to consider if any further actions are required.
- It's anticipated the completion of the remaining BAF actions for 2020/21 will further enhance the controls and assurances with the aim of reducing the risk to achievement of the strategic objectives.

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**

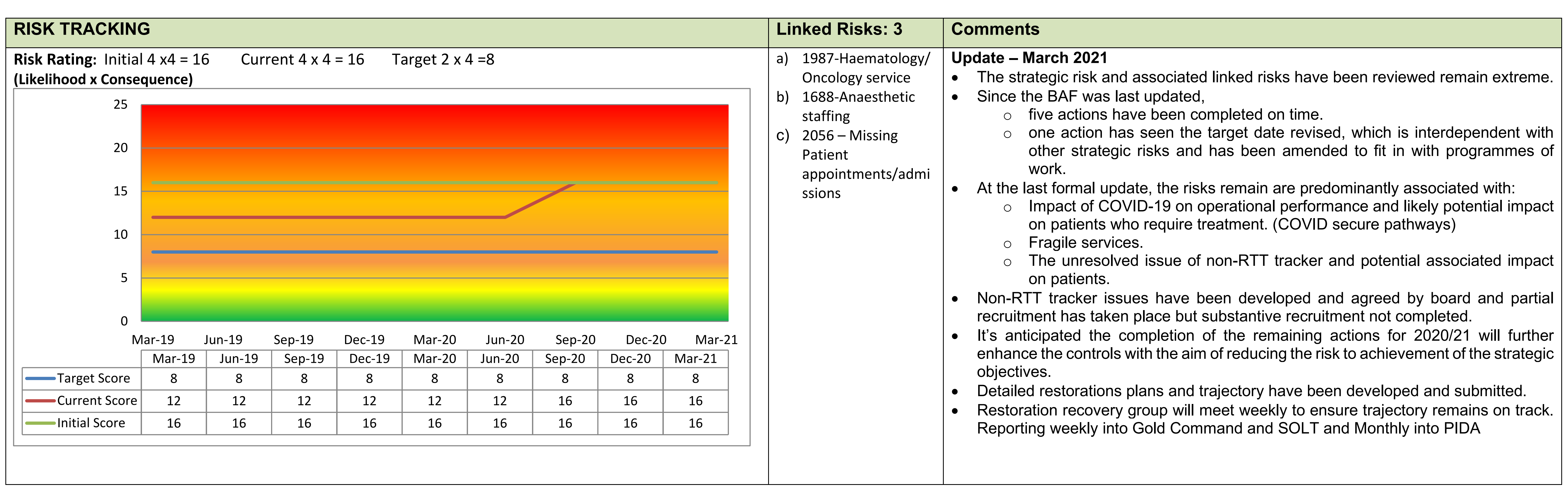
Inherent Risk			**Risk as at 31/03/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	4	4	**16**	2	4	**8**

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);	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 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. 20. System wide capacity and flow meeting held twice weekly to review system discharge delivery.	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: ○ Theatre Utilisation; ○ Patient Flow improvements; ○ Operational productivity; ○ 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 supporting internal assurance that the Trust complies to SITREP guidance against constitutional standards. 11. Weekly RTT restoration Group meeting in place from March 23rd to review performance against S&O plan **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. Quarterly report to FP&I on progress against each key constitutional standard to offer assurance in actions being taken to maintain and / or improve performance 3. S&O Urgent Care Board 4. OPIG key metrics agreed dashboard in review by BI to ensure integrated PMO approach	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. 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** 2. Out of hospital winter plan **Action Completed** – approved out of hospital (system) winter plan agreed. 3. Clinical workforce strategy to be completed – ~~by end of March 2021.~~ Revised deadline to end of Dec-21. 4. Engage system partners and agree sustainability plans for fragile services **– by end of March 2021.** 5. 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). 6. Develop sustainable plan to address validation issues in relation to the non-RTT tracker. – **Action on track for completion:** Plan and Business Case approved at Board and approach endorsed by NHSE/I. AfC approval not completed substantive recruitment outstanding 7. Develop local IPRs for CBUs – **COMPLETE – in place from end of July 2020.** 8. Recruitment for a Performance Manager post – **Completed:** Started in post November 2020. 9. Develop peer review boards – **Completed:** Peer assessments now in place across the system. 10. Use of Resources Group is now established first meeting to be held 29 March with DoF Chair 11. Business planning process in place, 'lite' in Q4 2020/21 full review due in Q1 2021/22 following national guidance

reputational damage; loss of public confidence.	21. Established Gold command of the day to ensure flow and clear escalation. 22. RTT restoration plan developed and detailed trajectory in place with recovery to 19/20 outturn defined by March 2022. 23. Comprehensive Service Review Programme developed and in progress includes but not limited to fragile services 24. Operational Improvement Group re-established to support standard, consistent and measurable PMO approach to service improvement 25. Fragile service programme in place; includes development of options and ongoing monitoring of progress 26. Use of Resources Programme established to support well led approach for clinical and corporate services.		**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 10. Urgent and Emergency System Board 11. Model Hospital dashboards and reports 12. Dr Foster reporting 13. Integrated QIPP reporting with CCGs		12. PMO alignment to CBUs to support standardisation of approach, independent reporting and QI approach.

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 – March 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 risks remain are predominantly associated with:
		  ○ Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment. (COVID secure pathways)
		  ○ Fragile services.
		  ○ The unresolved issue of non-RTT tracker and potential associated impact on patients.
		• Non-RTT tracker issues have been developed and agreed by board and partial recruitment has taken place but substantive recruitment not completed.
		• 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.
		• Detailed restorations plans and trajectory have been developed and submitted.
		• Restoration recovery group will meet weekly to ensure trajectory remains on track. Reporting weekly into Gold Command and SOLT and Monthly into PIDA

	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	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 31/03/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	**16**	3	4	**12**	3	4	**12**

Risks to objective

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.

Controls

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.

Gaps in Controls

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.

Sources of Assurances

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

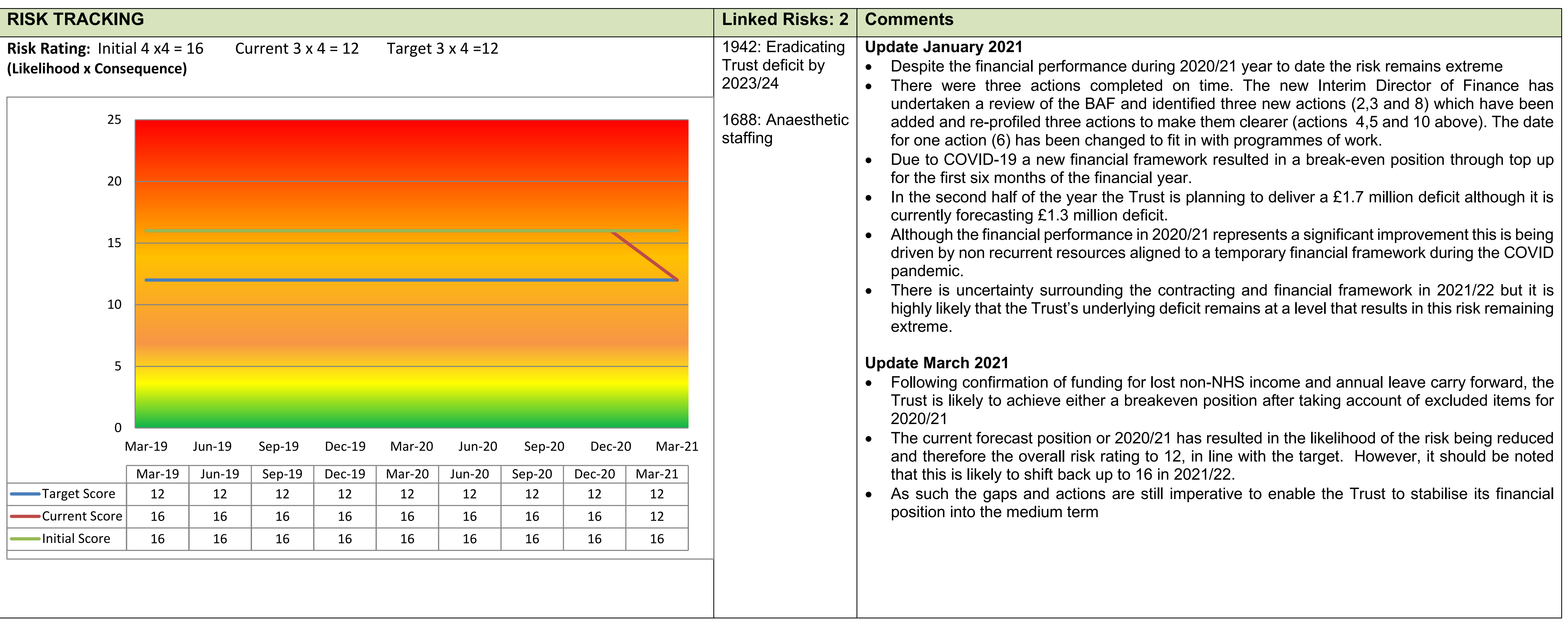
Gaps in Assurance

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.

Mitigating Actions/Progress

1. 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**
2. 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**
3. Develop financial framework to underpin Shaping Care Together programme, setting out affordability and potential financial improvement/recovery **– by end of March 2021**
4. Develop reporting mechanism to track progress with financial improvement recovery plan – **by end of March 2021.**
5. 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.
6. 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.
7. Establish process for identifying, implementing and monitoring delivery of efficiency/productivity (CIP) **– by end of February 2021.**
8. Implement and report progress against the Use of Resources action plan **– report to FP&I Committee by end of March 2021.**
9. E-rostering to be fully rolled out in all areas **– by end of March 2021.**
10. 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 3 x 4 = 12 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	12
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.

Update March 2021

- Following confirmation of funding for lost non-NHS income and annual leave carry forward, the Trust is likely to achieve either a breakeven position after taking account of excluded items for 2020/21
- The current forecast position or 2020/21 has resulted in the likelihood of the risk being reduced and therefore the overall risk rating to 12, in line with the target. However, it should be noted that this is likely to shift back up to 16 in 2021/22.
- As such the gaps and actions are still imperative to enable the Trust to stabilise its financial position into the medium term

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**

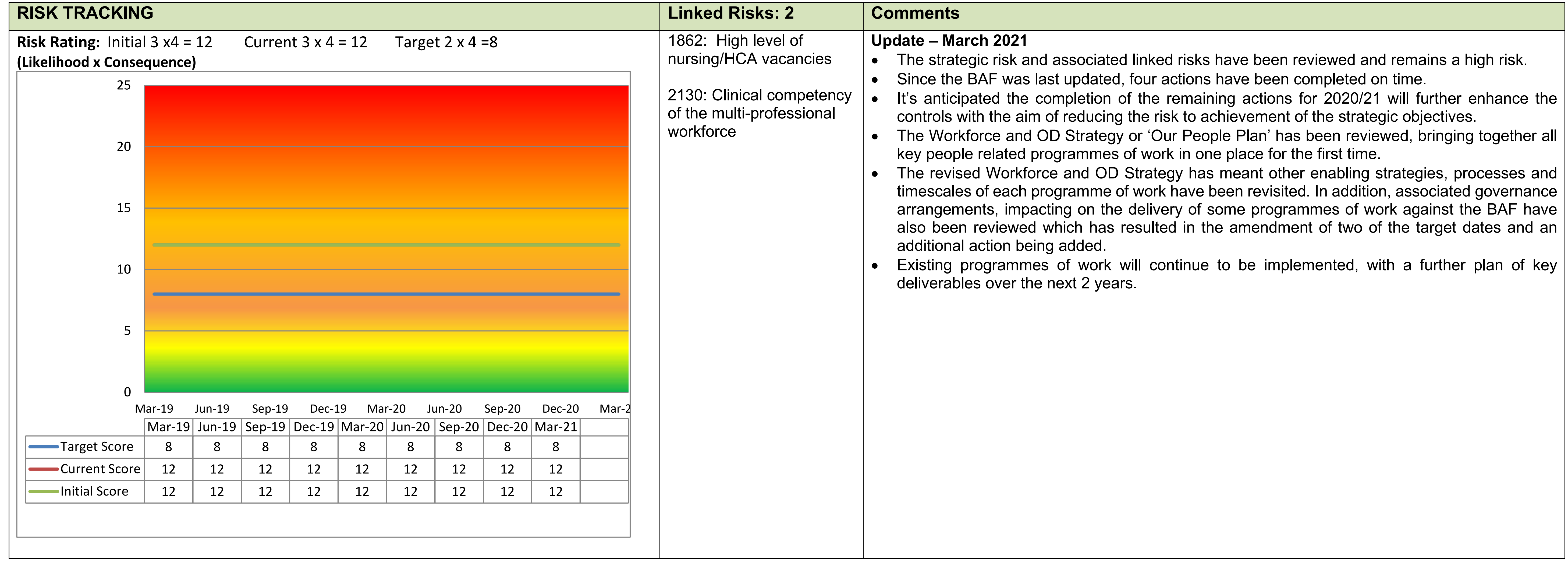
Inherent Risk			**Risk as at 31/03/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

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	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: ○ 3 x daily at staffing huddle; ○ 7 day staffing matron in place for oversight and management; ○ Weekly staffing review and sign off; ○ Roster sign off meeting. 15. Communication and Engagement Strategy and Plan 16. People Activity Group (PAG) 17. The Big Brew staff engagement programme. 18. 'At our Best' Leadership development programme 19. Supporting attendance policy.	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: 3. Job Planning 4. PDR's / Appraisals 5. Mandatory Training 6. Quality and Safety Committee 7. Clinical Effectiveness Committee 8. Finance, Performance and Investment Committee. 9. Risk and Compliance Group. 10. Clinical Effectiveness committee; 11. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 12. CBU Governance Meetings. 13. Deep dive into PDR/Appraisal Process completed and presented to Workforce Committee – Dec-20 14. PDR Action planning with CBU's. Trajectories in place and monitored at PIDA **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 15. Integrated Performance Report to Board and Workforce Committee (monthly): 16. Mandatory training; 17. PDR completion; 18. Sickness rates. 19. Absence Data 20. Turnover Data 21. Vacancy Rate 22. Time to Hire monitoring and reporting. 23. Staff Survey & Quarterly Staff FFT/Survey 24. GMC Medical Staff survey – annual 25. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 26. NHS England / Improvement	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 Update:** Our People Plan approved February 2021 and roll out commenced. 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. 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** 6. E-rostering to be fully rolled out in all areas **– by end of ~~March 2021~~ *September 2021.*** 7. Clinical Education Review in progress – to be completed by end of May 2021 8. Monitor sickness levels through integrated performance report and respond where appropriate - **Update:** Each CBU developing an improvement trajectory showing planned reduction in sickness absence over next 3 months and progress to be monitored through monthly PIDA. 9. 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.** 10. Develop an action plan in response to PDR deep dive **– by end of March 2021.** 11. Review of Trust onboarding and induction process in progress – to be completed by July 2021 12. Project focussing on CQC 'Must Do' action to improve reporting and monitoring of core mandatory & essential skills training in programmes – to be fully completed between April-July 2021

damage, loss of commissioner and patient confidence in provision of services.			27. CQC 28. CCG 29. NMC/GMC/HCPC and other professional regulators 30. Health Education England 31. Health Education North West 32. Internal/External Audit 33. Freedom To Speak Up Guardian (FTSUG) reports 34. Guardian of Safe Working Hours Report.		13. Three year roll out of Government HEE CPD Funding 2020-2023 available for Nurses, Midwives & AHP's to access HEI and development modules underway

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 – March 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 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	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 31/03/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	**12**	3	4	**12**	2	4	**8**

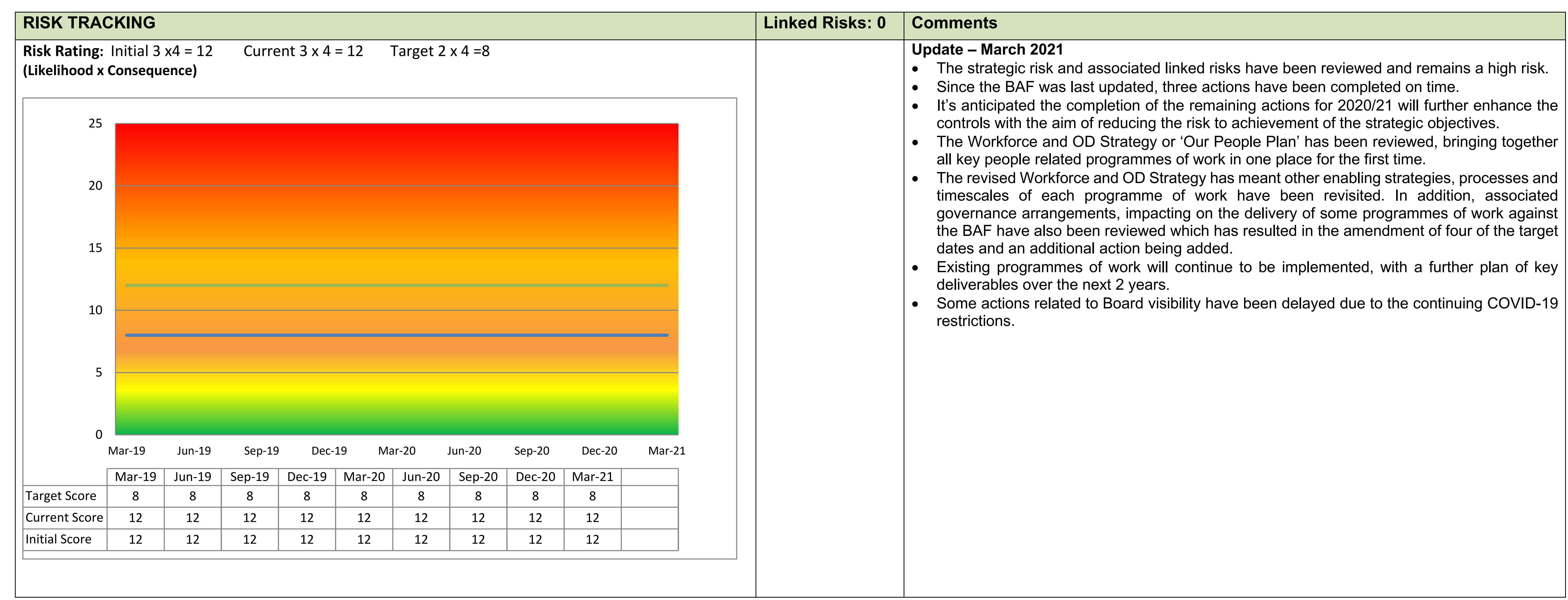
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours: leaders not always supported or developed; no 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 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;	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 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England	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. At our Best programme to re-commence in Spring 2021 following postponement due to the pandemic 7. Medical Leadership Programme for 28 x Consultants & SAS Doctors commenced 1st March 2021 for 6 months 8. Re-start board development sessions ~~– by end of October 2020 and ongoing.~~ **Update:** These had been delayed but board development sessions restarted in January 2021. However, latest guidance advises that Boards pause any Strategy / Development Sessions. Expecting to resume in August 2021. 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.

	○ 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.		6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		11. Review of E,D&I engagement with networks to agree an approach to increase engagement. **Update:** Newly established staff networks launched 16th March 2021. First meetings scheduled for 23rd March 2021. Representatives from staff networks to be invited to join Valuing Our People through Inclusion Group. 12. 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)

	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	12	
Initial Score	12	12	12	12	12	12	12	12	12	

Update – March 2021

- The strategic risk and associated linked risks have been reviewed and remains a high risk.
- Since the BAF was last updated, three 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.

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 31/03/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	5	**15**	3	5	**15**	3	3	**9**

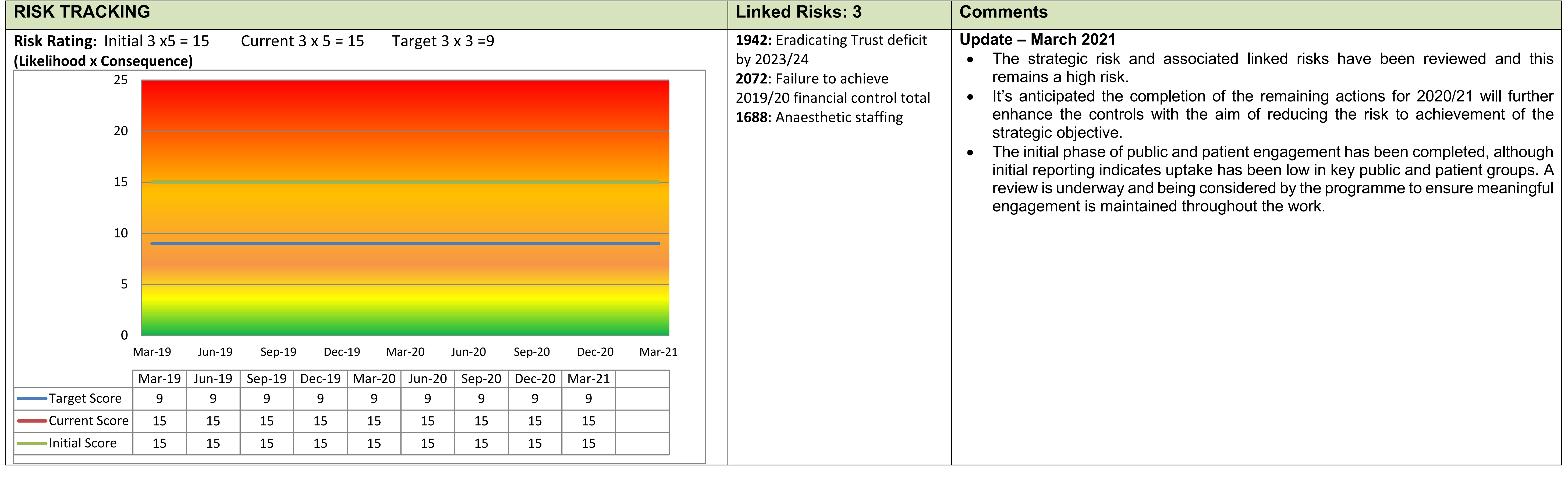
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to 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 income; poor estate utilisation due to inability to fully reconfigure services; unsustainability of a	1. Robust system governance in place, including: ○ Southport, Formby & West Lancs Programme Board: Shaping Care Together ○ Shaping Care Together operational groups: Delivery Group and Communication & Engagement Group ○ Southport, Formby & West Lancashire Clinical Leaders Group ○ Sefton Provider Alliance 2. Robust internal governance in place, including: ○ 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: ○ Finalised and agreed Shaping Care Together (SCT) programme plan for delivery ○ KPMG Case for Change ○ Sefton 2gether ○ West Lancs Building for the Future ○ Acute Sustainability Vision and Design Principles ○ 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.	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: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ 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. Southport, Formby & West Lancashire Joint Committee 2. Southport & Ormskirk Improvement Board - meets monthly.		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 and ongoing:** Patient & Public Advisory Group in development 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) established, models of care workshops booked for the end March 21 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 –** awaiting feedback from CMHCP/NHSEI on opportunities to access joined up legal advice. 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

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.	6. Quality and equality impact assessments completed and reviewed before any changes to Trust service provision. 7. System Equality Impact Assessment process established.		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.		Impact Assessment will be managed by CCC. 8. Programme to be monitored internally through Trust Board – **Action complete and ongoing** 9. Establish Finance and Capital Assurance Group with alignment to the System Management Board – **NEW ACTION:** work has commenced on the Drivers of Deficit work (operational, structural, strategic) which will form the basis of the finance and capital modelling work for the programme. The first meeting took place 12th March and an MOU is in development

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	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 – March 2021

- The strategic risk and associated linked risks have been reviewed and this remains a high risk.
- 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 initial phase of public and patient engagement has been completed, although initial reporting indicates uptake has been low in key public and patient groups. A review is underway and being considered by the programme to ensure meaningful engagement is maintained throughout the work.

Title of Meeting	BOARD OF DIRECTORS	Date	07 APRIL 2021
Agenda Item	TB054/ 21	FOI Exempt	No
Report Title	Board of Director's Annual Workplan and meeting dates for 2021/22		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ☐ To Receive	

Purpose

To purpose of this report is to present the Annual Workplan for review and approval.

Executive Summary

The Board of Directors should approve an annual workplan which identifies reports that will regularly be presented for consideration during the year. The Annual Workplan is one of the key components for ensuring that the Board of Directors is effectively carrying out its role in leading the Trust.

Appendix A details the annual workplan for 2021/22 meetings based on the previous year's workplans and is considered to be a comprehensive description of the regular business to be transacted by the Board.

The Board is asked to note that given the current situation with the Covid 19 pandemic, time limited reports have been added as part of the board business and will be kept under regular review to ensure that the Board is receiving accurate and timely reports on its own business and the external environment within which it operates.

Recommendations

The Board is asked to approve its Annual Workplan for 2021/22

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	Presented By:
Sharon Katema, ADCG	Sharon Katema, ADCG

Board of Director's Annual Workplan 2021/22

Agenda Item/Report	Purpose	Lead	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
PRELIMINARY BUSINESS														
Chairs welcome & note of apologies	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Declarations of Interests	Note	All	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Minutes of previous meeting	Approve	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Matters Arising	Receive	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Action Log	Approve	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
PATIENTS AND STAFF ENGAGEMENT														
Patient Story	Receive	DoN / Patient Exp. Matron	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Board Visits / Walkabouts	Receive	NEDs & Execs	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
STRATEGIC CONTEXT														
Chair's Report	Receive	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Chief Executive's Report	Receive	CEO	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Operational Plan	Receive	DoF	✓		✓			✓			✓			✓
QUALITY AND SAFETY														
*Infection Prevention and Control Assurance Framework	Receive	DoN	✓	✓	✓	✓								
Quality Improvement Plan	Receive	DoN / MD	✓			✓			✓				✓	
Learning from Deaths Report	Receive	MD	✓			✓			✓				✓	
Safe Nursing and Midwifery Staffing Report	Receive	DoN	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
CQC Progress Report	Receive	DoN	✓			✓				✓			✓	
Maternity Report	Receive	DoN			✓						✓			
Freedom to Speak Up Report	Receive	DoN / FTSUG		✓				✓			✓			✓
WORKFORCE														
Guardian of Safe Working Report	Receive	MD / GOSW		✓				✓			✓			✓
Medical Vacancies Report	Receive	MD			✓						✓			
Annual Staff Survey	Receive	DoHR&OD		✓						✓			✓	
OD Strategy / Our People Plan	Receive	DoHR&OD		✓						✓			✓	
PERFORMANCE														
Alert, Advise, Assure (AAA) Key issue reports	Receive	Committee Chairs	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Integrated Performance Report	Receive	All Execs	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Finance Report	Receive	DoF	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Winter Plan	Receive	COO							✓	✓	✓		✓	✓
REGULATORY, RISK AND CORPORATE GOVERNANCE														
Corporate Risk Register	Receive	ADCG	✓			✓			✓				✓	
Board Assurance Framework	Receive	DoN	✓			✓			✓				✓	
Compliance with Provider licence	Approve	ADCG		✓										
Annual Fit and Proper Person Declaration	Approve	ADCG		✓										
Annual Code of Conduct for Directors	Approve	ADCG		✓										
Final Annual Report & Accounts (including Annual Governance Statement & Quality Accounts)	Approve	ADCG		✓										
Annual Review of Trust Regulatory Documents and Statutory Registers	Approve	ADCG		✓										
Board Effectiveness and Performance	Approve	Chair			✓									
Committee Terms of Reference	Approve	ADCG						✓						
CONCLUDING BUSINESS														
Questions from members of the public	Receive	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Message from the Board	Approve	Chair / HOCM	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Meeting Evaluation	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
AOB	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Date and Time of next meeting	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓

Board of Director's Annual Workplan 2021/22

Agenda Item/Report	Purpose	Lead	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ANNUAL REPORTS														
Annual Resuscitation Report	Receive	Medical Director				✓								
Infection Prevention and Control	Receive	DoN / MD				✓								
Annual Patient Safety Report	Receive	DoN				✓								
Safeguarding Annual Report	Receive	DoN				✓								
Health and Safety Annual Report	Receive	DoN				✓								
Annual Emergency Planning Report	Receive	COO		✓										
Annual Complaints and Service Experience Reports	Receive	DoN		✓										
Guardian of Safe Working Annual Report	Receive	MD / GOSW		✓										
Freedom to Speak Up Annual Report	Receive	DoN / FTSUG		✓										

*Indicates time limited report