AGENDA
BOARD OF DIRECTORS' MEETING
To be held at 1000 on Wednesday 02 June 2021

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***1000***
TB083/21 (V)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*DoHR*	10 mins
TB084/21 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	Chair	5 mins
TB085/21 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB086/21 (D)	**Minutes of the previous meeting** *Purpose: To **approve** minutes of the meeting held on 05 May 21*	No	*Chair*	5 mins
TB087/21 (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				**1020**
TB088/21 (D)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*5 mins*
TB089/21 (D)	**Chief Executive's Report** *Purpose: To **receive** an update on key issues from the CEO*	*No*	*CEO*	*10 mins*
INTEGRATED PERFORMANCE				**1035**
TB090/21 (D)	**Integrated Performance Report (IPR) Summary** *Purpose: To **note** the IPR for assurance.*	*No*		
QUALITY & SAFETY				**1035**
TB091/21 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report	*No*	*Cttee Chair DoN/MD*	20 mins

	b) Quality and Safety Performance Report c) Summary Report of changes to IPC Assurance Framework *Purpose: To **receive** the Quality and Safety reports for information and assurance*			
TB092/21 (D)	**CQC Progress Report** *Purpose: To **note** the CQC Progress Report*	*No*	*DoN*	10 mins
TB093/21 (D)	**Annual Complaints and Service Experience Reports** *Purpose: To **receive** the Annual Complaints and Service Experience report*	*No*	*DoN*	10 mins
TB094/21 (D)	**Maternity Report** a) Maternity Services Report b) Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme c) Perinatal Mortality Review Tool *Purpose: To **receive** the Maternity Report*	*No*	*DoN*	15 mins
TB095/21 (D)	**Freedom to Speak Up Report** a) Q.4 Report b) Annual Report c) National Guardian's Office Annual Report *Purpose: To **receive** the Freedom to Speak Up Reports*	*No*	*Don/FSUG*	10 mins
OPERATIONS AND FINANCE				**1140**
TB096/21 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report b) Operational Performance Report *c)* Financial Performance Report *Purpose: To **receive** the FPI reports for information and assurance*	*No*	*Cttee Chair* *COO* *DoF*	15 mins
TB097/21 (D)	**Finance Reports** *a)* 2021/22 Financial Plan *b)* Month 1 Financial Position *Purpose: To **receive** and **approve** the 2021/22 Financial Plan and **note** the Month 1 Financial Position*	*No*	*DoF*	10 mins
WORKFORCE				**1205**

TB098/21 (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
CONCLUDING BUSINESS				**1215**
TB100/21 (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*
TB101/21 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*		*Chair*	*5 mins*
TB102/21 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	
	Date and time of next meeting: **13.30** Wednesday 09 June 2021 **10.00** Wednesday 07 July 2021			***1230 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**	

Board of Directors Register of Interests
as at 27 May 2021

NHS Southport and Ormskirk Hospital NHS Trust

NAME	POSITION /ROLE	Any Interests to declare	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	Date of review and update
ARMSTRONG-CHILD, Mrs Trish	Chief Executive Officer	No	Nil	Nil	Nil	Nil	25-Jan-21
BIRRELL, Mr Jim	Non-Executive Director	Yes	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	Yes	Director, St Joseph's Hospice Director, Pilkington Family Trust Trustee at The Rainford Trust	Nil	Nil	Nil	20-Jan-21
GIBSON, Mrs Pauline	Non-Executive Director Designate	Yes	Director: Excel Coaching and Consultancy	Nil	Nil	Nil	28-Jan-21
HANKIN, Dr Terrence	Medical Director	No	Nil	Nil	Nil	Nil	27-Jan-21
KATEMA, Mrs Sharon	Associate Director of Corporate Governance	No	Nil	Nil	Nil	Nil	26-Jan-21
LEES, Ms Bridget	Director of Nursing, Midwifery and Governance	Yes	Nil	Nil	Nil	Spouse employed by Trust as Pharmacy Technician	27-Jan-21
MASOM, Mr Neil	Chairman & Non- Executive Director	Yes	JSSH Ltd NDLM Ltd The Foundry (Loughborough) Management Company Ltd Seashell Trust	Nil	Nil	Nil	27-Jan-21
McLuckie, Mr John	Director of Finance	No	Nil	Nil	Nil	Nil	25-May-21
Neary, Ms Lesley	Chief Operating Officer	No	Nil	Nil	Nil	Nil	25-May-21
POLLARD, Mr Graham	Non-Executive Director	Yes	Employed by Royal Agricultural University	Nil	Nil	Nil	15-Mar-21

Board of Directors Register of Interests
as at 27 May 2021

NAME	POSITION /ROLE	Any Interests to declare	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	Date of review and update
ROYDS, Mrs Jane	Director of Human Resources& Organisational Development	Yes	Nil	Nil	Vice Chair of Governors, Farnborough Road Junior School, Southport	Nil	28-Jan-21
Russell Mrs Nina	Director of Transformation	Yes	Substantively employed by NHSE/I	Nil	Nil	Nil	06-Apr-21
SHANAHAN, Mr Stephen	Director of Finance	Yes	Board Trustee – Age Concern Central Lancashire	Nil	Nil	Nil	05-Feb-20
SINGH, Mr Gurpreet	Non-Executive Director	Yes	GS Urology Ltd: providing practice & GMC work Private practice at Ramsay Health Honorary Professorship with Bolton University	Trustee of the Southport and District Medical Education Centre Fund Trustee at BAUS (British Association of Urological Surgeons)	Nil	Nil	28-Jan-21

Draft Minutes of the Board of Directors' Meeting
Held on Microsoft Teams
Wednesday 05 May 2021
(Subject to the approval of the Board on 02 June 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
Mrs Pauline Gibson	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 Gurpreet Singh	Non-Executive Director
Mr Steve Shanahan	Executive Director of Finance *(Part 2)*

In Attendance

Mr Paul Chadwick	Head of IT *(Item PB030/21)*
Mr Ajl Anto Chalissery	Registered Nurse, ITU *(Item TB059/21)*
Mr Tony Ellis	Communications and Marketing Manager
Mrs Carol Fowler	Assistant Director of Nursing (Workforce) *(Item TB059/21)*
Dr Sharryn Gardner	Guardian of Safe Working *(Item TB072/21)*
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Chrisella Morgan	Deputy Chief Operating Officer *(Part 1)*
Dr Craig Rimmer	Chief Clinical Officer *(Item PB030/21)*
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Nina Russell	Director of Transformation
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance
Mr John Williams	Chief Pharmacist (*Item PB030/21)*

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB059/21	**Staff Story**	

(Mrs Fowler and Mr Chalissery joined the meeting)

Mr Chalissery, a registered nurse in ITU, shared his story outlining his experience as one of the initial cohorts of international nurses to join the Trust and thanked the Board for the opportunity. He outlined that having worked as a nurse in India for seven years, he aspired to work in another country and had been encouraged by his mentor to explore opportunities which led to him applying to join the Trust.

Mr Chalissery outlined that overall, the transition and welcome from colleagues within the Trust was commendable and he was proud to be part of the first cohort that had now progressed into substantive roles. These had been achieved through completion of the externally assessed Objective Structured Clinical

Examination (OSCE) adding that his fellow nurses had all passed the examination. Mr Chalissery commended the staff involved in the delivery of their training and mentorship particularly during the supernumerary period, for their guidance and support and the key role they played in making his goals a reality. He also thanked all Trust staff for their goodwill, emotional and welfare support as they settled into their new roles and established their new homes. However, given the current climate and challenges with the pandemic, in common with his colleagues, Mr Chalissery, missed their families and were relieved to know that their loved ones were safe but the situation in India remained dire due to the high number of Covid-19 cases.

Mr Masom thanked Mr Chalissery for sharing his story and agreed that it was a challenging time in his home country and was looking forward to seeing him around the Trust.

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

(Mrs Fowler and Mr Chalissery left the meeting)

TB060/21 Chair's welcome and note of apologies

Mr Masom welcomed all in attendance and in particular welcomed Mrs Russell to her first meeting as Director of Transformation and Dr Clarke and Mr McLuckie who were observing the meeting. There were no apologies for absence.

Mr Masom highlighted that this was Mr Gregory's last meeting as Interim Director of Finance and thanked him for his contribution to the Trust and to the Board.

TB061/21 Declaration of interests

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

TB062/21 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 07 April 2021 and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Board **approved** the minutes from the meeting held on 07 April 2021.

TB063/21 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

TB064/21 Chair's Report

Mr Masom presented his report which detailed the activities undertaken since the previous meeting. He thanked all staff for their ongoing commitment and hard work in addressing the challenges relating to Covid-19 noting that on 30 April 2021 the Trust had reached a significant milestone as there had been no Covid-19 cases in the Trust for the first time in 400 days.

Mr Masom outlined that since the last meeting:

- He had attended the North West (NW) Regional Chairs call were there was now a noticeable shift in focus from working with Covid-19 to restoration and recovery. Any contingency planning for a potential increase in cases in the autumn would be dealt with as a part of the winter planning.
- The recruitment process for an Associate NED was underway with shortlisting and interviewing expected to take place during May.
- The Charitable Funds Committee met on 21 April and approved funding requests for projects around staff health and wellbeing after Covid-19.

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

TB065/21 Chief Executive's Report

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

- Awards and Recognition –
  - Thanks a Bunch Award had been awarded to the Organisation Development Team, Infection Prevention Control Team, and Safeguarding Team:
  - Publication of Mr Kartik Iyengar's paper on BAME vaccine hesitancy which available to read on PubMed or BMJ websites.
  - Apprenticeship achievements for Sheila Haslam and Nicci Stutt.
- Acknowledging the Covid-19 situation in India and the links with staff within the Trust, a Health and Wellbeing (HWB) event had been held on 1 May to offer support to any staff.
- Whilst 91% of staff had been vaccinated, plans to close the temporary vaccination hubs were being finalised with a view that the service remained accessible for the staff who wished to receive the vaccination. An additional clinic had also been set up for 30staff who had subsequently confirmed that they wished to take up the vaccine. Discussions were ongoing at both national and regional level around the rollout of additional vaccines in the Autumn.

- Seven volunteers had completed the 8-week Programme Volunteer Improvement Programme which had been specially designed for the Trust and funded by NHSE.
- The Spiritual Care Champions service had been launched with 10 members of staff had expressed an interest in becoming Champions.
- As work had commenced on Fragile services, there would be a systematic review of the risk register.

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

COVID-19-19 UPDATE

TB066/21 Covid-19 Update

a) Covid-19 Update

Ms Lees led on the delivery of the presentation which provided a review of the past year. The team had spent time looking back at the early interventions that had been put into place which had enabled the Trust to respond quickly to the situation. These interventions which included Command and Control structures which were led by Executive and Clinicians, the appointment of a medical liaison officer which had played a pivotal role in the early days as well as the inception of the daily sitrep.

Mr Gregory commented that the work that had been carried out during April and May had set the foundations for how the Trust had managed the pandemic for the remainder of the year. This foundation had also shaped the way to work differently in future. It was important to note the contributions that had been made by the IT and Estates and Facilities teams during this period.

The Workforce Directorate had reacted quickly to ensure that staff had felt supported and Mrs Royds commented that she had received feedback from the 40 families who had made use of the free childcare that had been arranged. The Organisational Development (OD) team had provided support to the 100 shielding members of staff and all bar 3 members had now returned to work.

The December 'Month of Thank You' had been greatly appreciated by the staff. Each day, a recorded message from a celebrity was shared with staff across different social media platforms and email. In addition, the CEO signed and send a personalised thank you card to every member of staff, that had been designed in partnership with a local primary school.

Dr Hankin advised that like all trusts, the Trust had faced staffing challenges within Critical Care which had no impact on the quality of care delivered to patients who were assessed on a clinical basis. It was also noted that the unit had expanded its footprint during this time to cope with the increase in demand.

Dr Hankin commented that, on personal reflection, things were easier in certain respects but the restoration and the unknown cost to the public would be challenging going forward. In conclusion, Mrs Armstrong-Child commended the team for their leadership and effort and for overall presentation which provided an inspirational review of the year.

Noting Dr Bricknell's comment regarding the daily Situation Reports (SITRep) which were circulated to NEDs ensuing they were kept abreast of the operational pressures, Mr Masom thanked the NEDs for maintaining focus on assurance which was challenging given the restrictions on visiting and the transition to virtual meetings. He also

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

b) Summary Report of changes to IPC Assurance Framework

Ms Lees presented the Summary Report which provided an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Assurance Framework. She outlined that the action plan was nearing completion as four actions had been closed in the previous month and further four actions were being addressed once additional evidence was provided.

RESOLVED
The Board **received and noted** the changes to the IPC Assurance Framework

INTEGRATED PERFORMANCE

TB067/21 Integrated Performance Report (IPR) Summary

The Board noted the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local priorities during March 2021.

QUALITY AND SAFETY

TB068/21 Quality and Safety Reports

a) Committee Highlight Report

Dr Bricknell presented the report following the Quality and Safety Committee meeting held on 26 April 2021 and highlighted that there were no alerts to escalate to the Board. The Committee advised that:

- A review was being conducted into the TIA issues raised by the recent MIAA report presented to the Audit Committee. A programme for action as well as a report detailing any indication of harm to patients would be presented to the Committee at the meeting in May.
- Whilst the restoration plan, and the actions in relation to Fragile Services, indicated a potential lessening of risk, there was an expectation that the

System would be working as a whole and that this may have an adverse impact for some patients.

The Committee took assurance that the Trust had been below the regional average for infections following a review of nosocomial Covid-19 infections. It was noted that there had been no nosocomial Covid-19 infections reported during the last wave which was testament to the effectiveness of the IPC measures deployed across the Trust.

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

b) Quality and Safety Performance Report

Ms Lees presented an overview of the Trust's performance against the quality and safety standards. She outlined that following on from the reported increase in pressure ulcers, an action plan was now in place and this would be monitored through the Harm Free Care Panels.

Dr Hankin advised that:

- the decline in Sepsis had been noted and that patients were being reviewed as there was a possibility that there had been diagnostic errors.
- there had been reduction in Stroke and Transient Ischaemic Attacks (TIA) following the implementation of the recommendations included in the MIAA report.
- work was ongoing to understand the drivers around the increase in the Summary Hospital-level Mortality Indicator (SHMI).

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

OPERATIONS AND FINANCE

TB069/21 Finance, Performance, and Investment (FPI)

a) Committee AAA Highlight Report

Mr Pollard presented the report detailing discussions held at the FP&I meeting. An alert relating to the lack of confirmation of the income levels that the Trust would receive in 2021-22 had been noted. He advised that in addition to the Emergency Preparedness, Resilience and Response (EPRR) annual report and the EPMA business case which were being commended to the Board, the Committee had received reports relating to:

- the restoration operational plan which included a more detailed breakdown of referral rates and that further work had been requested to explore any correlation in trends between the two.
- The review of target metrics and variations within the IPR

- The Use of Resources progress report had illustrated the identified savings and set out the role of an Efficiency Board in driving the Cost Improvement Programme.

The Committee was assured that the Trust had demonstrated progress on good financial management by recording a small surplus as well as investing almost all capital funding received.

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

b) Operational Performance Report

Mrs Morgan presented the Operational Performance Report which provided a summary of operational activity against the constitutional standards. The report indicated that 14 of the 24 indicators had shown a positive trend and that the conversion rate within the Emergency Department (ED) had dropped due to an increase in admission of high acute patients resulting in an increase in bed occupancy. She added that the increase in the number of theatre cases, theatre utilisation, and bed occupancy would form part of the restoration plan.

In response to Mr Birrell's query around the number of long waiters and the need for additional capacity Mrs Morgan advised that all patients had been risk assessed and a plan had been put in place which would result in the reduction of the 52 week waiters. Mrs Armstrong-Child commented that this had been discussed at both Gold Command and ETM and that it was clear that the trajectory would worsen before it improved.

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 and advised that the three adverse metrics, namely the pay and non-pay run rate and bank/agency run rate had deteriorated in March. The deterioration could be attributed to the adjustments made in month 12 which had related to multiple months and could distort the metric.

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 March 2021. The report outlined that the Trust was expected to achieve a surplus of £125,000 for the financial year 2020/21 subject to the finalisation of accounts and audit. He added that the effect of the Trust's estate impairment would not affect the reported surplus as this would be treated as a technical adjustment and had been presented to FP&I. Funding for the new financial year had not been settled but the Trust had been provided with provisional figures which included figures for Covid-19 and top-ups. It was noted that these figures could be amended as the System attempted to achieve a breakeven position.

Mr Gregory commented that the Cost Improvement Plan (CIP) had not been achieved adding that the shortfall would require more focus during the financial year. It was noted that a paper had been presented at ETM around the development of CIP for the financial year.

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

TB070/21 Annual Emergency Planning Report

a) Annual Emergency Planning Report

Mrs Morgan presented the Annual Emergency Planning Report which detailed the activity in relation to Emergency Preparedness within the Trust from April 2019 to March 2021. She advised that as a Category one responder, the report provided a retrospective view and the legal obligations as emergency responder. It was noted that an action plan had been put in place to enable the completion review of the Business Continuity Plan (BCP). The Trust had not conducted any external exercises due to the pandemic but had completed and submitted an annual self-assessment based around Covid-19.

Mr Pollard provided assurance that the report had been approved at FP&I with minor amendments and was recommended to the Board for approval.

RESOLVED
The Board **received** and **approved** the Annual Emergency Planning Report.

b) Policy for Emergency Preparedness Resilience and Response (EPPR)

Mrs Morgan presented the Policy for Emergency Preparedness Resilience and Response (EPRR) for approval. It was noted that, whilst the EPRR did not contain details on plans and procedures in place for incident response, it outlined the requirements of the Trust in accordance with the Civil Contingencies Act (CCA) 2004 and NHSE/I EEPR Framework which included the roles and responsibilities, plans and procedures in place training and exercising requirements.

RESOLVED
The Board **approved** the Policy for Emergency Preparedness Resilience and Response

WORKFORCE

TB071/21 Workforce Committee

a) Committee AAA Highlight Report

Mrs Gibson presented the report and alerted the Board that whilst Personal Development Reviews (PDRs) remained an area of concern. However, targeted actions on approach, engagement and creating the time for a PDR were expected to provide a more positive trajectory and address the low compliance levels.

The meeting had received reports regarding the following areas:

- Sickness absence rates, including Covid19 related sickness, had decreased for most staff cohorts. Initiatives to support with attendance included:
    - An HR advisory service which supported and provided managers with essential skills training for the practical management of sickness.
    - The Ambassadors for Hope and REACT training would support the initiation of wellbeing conversations in the context of stress/anxiety, which was a major cause of ongoing absence.
- The decrease in agency spend due to the drop in demand and an increase in bank fill spend due to the incentive scheme.
- In view of the establishment of an Education Governance Framework, a review of the Clinical Education had been commissioned and focussed on education governance, funding streams and infrastructure and resources.

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

b) Workforce Performance Report

Mrs Royds presented an overview of performance against the workforce indicators during March 2021 advising that whilst mandatory training had remained above the 85% target this was being monitored to ensure there was continuous compliance. Sickness Absence remained an area of concern and continued to be reviewed each week at Gold Command.

Mr Singh's queried if the increase in the rolling sickness rate was Covid-19 related. Mrs Royds responded that this increase was mainly related to stress, anxiety, bereavement, cancer cases and musculoskeletal (MSK) reasons and provided assurance that work was ongoing to support staff to remain in work or to be absent for the shortest time possible.

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

TB072/21 Guardian of Safe Working Report

(Dr Gardner joined the meeting)

Dr Gardner presented the 2020/21 Guardian of Safe Working (GOSW) Annual Report which provided an update on the issues of compliance with safe working hours and sought to assure the Board that the doctors working hours were safe. The report detailed that the trainees:

- Were grateful for the care and support during the pandemic and were reassured by the availability of Personal Protection Equipment (PPE) and the provision of free hot meals throughout the pandemic.
- Felt there was a missed opportunity for training as they struggled with dropping a rotation during the first wave. It was noted that the Trust had minimal redeployments during this period and that this had been well managed.
- There had been sporadic specific issues in Exception Reporting, and these were mainly around scheduling for on calls which had resulted in significant daytime gaps.

With regards to the exception reports, it was noted that the reports were mainly from Southport site as most Foundation doctors were based at Southport. Dr Hankin added that most of the exception reports relating to overtime were within the 30minutes to one-hour range.

Noting that Dr Gardner would be stepping down as GOSW, Mrs Armstrong-Child expressed her thanks on behalf of the Board for the contribution that Dr Gardner had made during her time as GOSW.

RESOLVED:
The Board **received** and **approved** the Guardian of Safe Working Report

(Dr Gardner left the meeting)

RISK AND GOVERNANCE

TB073/21 Audit Committee Reports

a) Audit Committee Highlight Report

Mr Birrell presented the AAA highlight report from the meeting held on 14 April 2021 and drew attention to the alert relating to the two limited assurance internal audit reports that had been considered by the Committee regarding staff appraisals and Stroke/TIA targets. The Committee had considered the actions being undertaken to address the recommendations from the reviews and would continue to monitor progress at future meetings.

Mr Birrell advised that following the request by the Board for the Audit Committee to review the Board Assurance Framework (BAF), it had been agreed that the next iteration of the BAF would include comments expressed by assurance committee chairs regarding gaps in controls. Consideration would also be given

to ensuring that the document placed greater emphasis on significant key controls and assurances so that appropriate attention would be paid to material issues.

RESOLVED:
The Board **received** the Committee Highlight Report for assurance and information.

b) Audit Committee Annual Report

Mr Birrell presented the Audit Committee Annual Report which outlined the work undertaken and/or overseen by the Audit Committee in 2020/21 in assessing the effectiveness of the Trust's risk management, assurance and governance arrangements. It was noted that whilst the degree of scrutiny and review undertaken by the Committee over the last year had been affected by the impact of Covid-19, the work that had been completed suggested that systems and processes had been strengthened in 2020/21.

RESOLVED:
The Board **received** the Annual Report for assurance and information.

TB074/21 Compliance with Provider Licence

Mrs Katema presented the report which asserted that there was substantial evidence to suggest that the Trust was compliant with the relevant requirements of the NHS Self-Certification for the Provider Licence. The Board reviewed and approved the following self-certifications:

- **Condition G6-**(2) by 31 May - which required NHS Trusts to have processes and systems that identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to prevent them from occurring
- **Condition FT 4:** which required that:
  - Providers reviewed whether their governance systems achieved the objectives set out in the licence condition.
  - Compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

RESOLVED:
The Board **reviewed** the evidence and **confirmed** compliance with the NHS Self Certification for the NHS Provider Licence

TB075/21 Annual Fit and Proper Person Declaration

Mrs Katema presented the report which provided assurance that members of the Board of Directors were compliant with the regulatory requirements of the Fit and Proper Person Tests. It was noted that Southport and Ormskirk Hospitals NHS Trust had undertaken the appropriate checks and was satisfied that, on

appointment and subsequently, all new and existing Directors were of good character and were not unfit. This was ascertained through the following means:

- individual declarations undertaken as part of the annual appraisal,
- full checks on the new members of the Board
- annual self-declarations completed each May by all members.
- a review of personnel files undertaken as part of due diligence checks.

RESOLVED:
The Board **received** the Annual Compliance with Fit and Proper Person's report as confirmation of compliance against the regulations for the Fit and Proper Persons Test

TB076/21 Register of Sealings

Mrs Katema presented the report which provided the Board with details on the use of the Trust's Seal during the 2020/21 financial year. She advised that during the financial year, the Common Seal had not been affixed and therefore there was no entry in the Register of Sealings for the reporting period.

RESOLVED:
The Board **received** the Register of Sealings.

TB077/21 Policies for Approval

Mrs Katema presented the following Corporate Policies for approval following a periodic review:

a) Fit and Proper Person's Policy and Procedure
b) Standards of Business Conduct and Manging Conflicts of Interests Policy
c) Freedom to Speak Up Policy

It was noted that, whilst the policies remained in line with the Trust's statutory and regulatory requirements, minor amendments had been made to the policies reflecting feedback from Internal Audit and Assurance Committees. These changes were outlined in the version control which was on the last page of each policy.

It was agreed that the Freedom to Speak Up Policy would be presented at the next Audit Committee for approval.

RESOLVED:
The Board **approved** the Corporate Policies for a period of three years in line with the Trust's Policy Management Framework subject to Audit Committee reviewing and approving the Freedom to Speak up Policy.

CONCLUDING BUSINESS

TB080/21 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.

TB081/21 Message from the Board

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

TB082/21 Any Other Business

In concluding the meeting, Mr Masom thanked Mr Gregory for his support and contribution during his time with Trust.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:29

Board Attendance 2021/22												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Neil Masom (Chair)	✓	✓										
Trish Armstrong-Child	✓	✓										
Jim Birrell	✓	✓										
David Bricknell	✓	✓										
Bridget Lees	✓	✓										
Steve Christian	✓											
Bill Gregory	✓	✓										
Pauline Gibson*		✓										
Julie Gorry	✓	✓										
Terry Hankin	✓	✓										
Graham Pollard	✓	✓										
Steve Shanahan	A	✓										
Gurpreet Singh	✓	✓										
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓											
Sharon Katema	✓	✓										
Jane Royds	✓	✓										
Nina Russell		✓										
✓ = In attendance A = Apologies												

**became a voting member of Board*

Board of Directors (Part 1)

Matters Arising Action Log

Action Log updated 27 May 2021

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
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:** A Patient Story around the impact of screens on elderly patients to be presented at a future Board meeting.	**Amber**
TB051/21	07-Apr-21	**Annual Staff Survey**	With regards to seeking external support from other Trusts, it was agreed that, whilst this would be a good option, it would need to be approached with caution as each Trust worked in a unique way. It was agreed that a quarterly progress update around the actions outlined in the Annual Staff Survey feedback report would be presented.	**DoHR**	07-Apr-21	07-Jul-21	**April Update:** A report around progress against the actions be presented quarterly.	**Green**

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
TB052/21	07-Apr-21	**Board Assurance Framework (BAF)**	Mr Masom requested a review of the BAF to be undertaken by the Audit Committee meeting and an update to be included in the AAA report for review at Board in May	**Chair of Audit Cmmtt**	07-Apr-21	05-May-21	**April Update:** The Audit Committee to review the BAF and provide an update in the AAA report for review at Trust Board in May **29 April Update**: Included on Agenda for 07 May meeting. **Action completed**	**Blue**
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	**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 **May Update:** A report was presented at the Quality and Safety Committee meeting. **Action completed**	**Blue**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB088/21**	**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 apprise the Board of Directors of the Chair's activity since the last Board meeting held on 5 May 2021. The report provides a brief update on

- CQC Inspection, which is included on the agenda.
- The retirements of Dr Terry Hankin as Medical Director and Steve Shanahan as Director of Finance.
- The appointment of Ian Craig as Associate Non-Executive Director

Recommendations

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

Previously Considered By:

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

Strategic Objectives

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

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

1. Introduction

1.1 At our Board meeting held on 7 March 2021, I advised that the CQC had arrived at the Trust for an unannounced inspection of our medical services. I am pleased to advise that the Inspection Report was published on 13 May 2021 and is included on this month's agenda. The inspectors identified significant improvements across all the areas they reviewed since their last inspection.

1.2 On behalf of the Board, I would like to formally thank all staff for their continued hard work, compassion, and commitment to delivering high quality care to our patients.

2. Changes to the Board

2.1 This month I will begin by formally thanking our executive directors who will be leaving this Trust this June.

- Dr Terry Hankin will be retiring from his post as Medical Director after more than 30 years' service to the NHS. Terry joined us from St Helens and Knowsley Teaching Hospitals NHS Trust where he was Deputy Medical Director and Responsible Officer. His knowledge and experience as an active critical care physician and anaesthetist has been especially valuable in helping us manage the Covid-19 pandemic. Dr Hankin had continued in post after his official retirement last summer but will finally hang up his scrubs this Friday 5 June.

- Steve Shanahan, Director of Finance is retiring after more than five years with the Trust. Steve joined us on secondment from North Cumbria University Hospitals NHS Trust in November 2015 where he was Executive Director of Finance before being appointed to the substantive post in August 2016. He had a career at Board level in the private sector before joining the NHS in 2005.

2.2 I am pleased to formally welcome our new executive directors who are joining the Trust this June.

- John McLuckie joins us as Director of Finance from North West Boroughs Healthcare where he held the role of Chief Finance Officer from July 2018. John joined the NHS in 1988 as a graduate trainee and has worked in the NHS provider sector within acute, community, mental health and learning disability services.

- Lesley Neary joins as our Chief Operating Officer from Lancashire Teaching Hospitals NHS Foundation Trust where she held the role of Deputy Chief Operating Officer. Lesley joined the NHS in 1999 and has worked across a number of NHS sectors including acute, regulatory, community and commissioning.

- Dr Kate Clark joins us from Monday 6 June, as Medical Director. Kate joins us from Betsi Cadwaladr University Health Board, where she was the Medical Director for secondary care across the three hospitals in North Wales. Kate trained at Liverpool Medical School and started her career as a consultant in emergency medicine at the Royal Liverpool Hospital.

3. We have just completed a successful recruitment campaign for an Associate Non-Executive Director, and I am pleased to announce that NHSE/I have confirmed the appointment of Ian Craig as an Associate Non-Executive Director. Ian will be joining the Trust this June.

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Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 June 2021**
Agenda Item	**TB089/21**	**FOI Exempt**	**NO**
Report Title	**CHIEF EXECUTIVE OFFICER'S REPORT**		
Executive Lead	Trish Armstrong-Child, Chief Executive Officer		
Lead Officer	Trish Armstrong-Child, Chief Executive Officer		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The attached briefing paper provides some high-level updates on activities within the Trust since the previous meeting of the Board of Directors in November. These include:

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

Recommendation

The Board is asked to receive the report for information.

Previously Considered By:

N/A

Strategic Objectives

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

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

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 So Proud Awards

These were staff members nominated by a colleague and recognised this month with a SO Proud badge for going to extra mile:

- Kim Lucey – Sister, Spinal Unit
- Louise Lancaster - ITU
- Heidi Moran - complaints team
- Lesley Brant - PALS liaison
- Kathryn Mullen - PALS liaison
- Michaela Hadwin - HCA maternity
- Dawn Nicholson - AfC administrator HR
- Jo Forshaw – endoscopy scheduling manager
- Erica Isherwood – Sister corporate nursing

1.2 Thanks a Bunch

Three teams were recognised in May for their work with a Thanks a Bunch award. They were:

- 10A (acute medical unit)
- 7B (rehab)
- Discharge Lounge

1.3 Care Certificates

The following staff succeeded in achieving their Care Certificates in May:

- Peter Bryan
- Chris Butler
- Carol Smith
- Hayley Cook
- Dermot Furlong

1.4 Neonatal Unit Award

Finally, well done to the Neonatal team at Ormskirk Hospital who successfully secured UNICEF UK Baby Friendly accreditation. As part of their application, the team put together a video which shows members of the team explaining their roles and the work they carry out.

2. News and Developments

2.1 CQC finds improvement across all inspected areas at Southport Hospital

The Care Quality Commission (CQC) published their report on 13 May 2021, following an unannounced inspection of our medical service at Southport and Formby District General Hospital in March 2021.

The inspectors identified significant improvements since their last inspection in 2019 across all

the areas they reviewed. They also noted staff spoke positively about the culture in the hospital and the support and visibility of the leadership teams on the medical wards.

These improvements are the result of the hard work of staff, and their compassion, dedication and commitment to delivering high quality patient care every day. It is particularly encouraging this was achieved at such a challenging time for everyone working in healthcare.

However, we recognise that the organisation continues to be on an improvement journey and it was assuring to note that the leadership team had already identified areas the CQC had highlighted in the report that we should continue to improve on were already being addressed at the time of the inspection.

Due to the focused nature of the inspection, services were not rated and our overall Trust rating (*currently "requires improvement"*) will be reviewed at our next full inspection.

3. Trust News

3.1 Health and Wellbeing Team Pass 20,000 Vaccination Landmark

May saw the Trust pass a landmark 20,000 Covid-19 vaccinations, mostly at our vaccination suite at Southport hospital. Our initial focus was on staff with 92% now vaccinated. We have also vaccinated fellow health and social care colleagues as well supporting the national campaign with vaccinations for close family members of staff.

I want to thank everyone who has participated in this important public health programme which is now helping life in our community return to normal. Also, a big thank you to our Health and Wellbeing team who have led this work.

3.2 International Nurse Recruitment

International recruitment of nurses is key pillar of our strategy to reduce registered nursing vacancies within the Trust.

A total of 68 international nurses have been recruited – although arrivals from India have been paused until the Covid-19 emergency there resolves. We welcomed a further nurse from the United Arab Emirates on 21 May.

All but one of 45 nurses who have sat their Objective Structured Clinical Examination (OSCE) exam have passed. A pass in this examination is requirement to apply to practice as a registered nurse in the UK. The remaining international nurses will sit their exams shortly.

3.3 Hospital Visiting

To protect patients, staff and the community, patient visiting at Southport and Ormskirk Hospitals has remained restricted since wave one of the pandemic. This was a difficult but necessary decision which I know has been hard for some patients, their families, and staff alike.

Continued higher than average community rates of Covid-19 infection within our locality has led to restrictions remaining in place. However, we review the restrictions with the local NHS each week and hope to begin lifting them as soon as conditions allow.

Special arrangements are in place for certain patient groups including maternity, children, vulnerable patients, and those at the end of life. Our visiting page has further information, we would encourage all families who may have any concerns regarding.

3.4 Ward Refurbishment Programme Back on Track

Our ward refurbishment programme that started at Southport hospital early in 2020 is back on track after being halted by the Covid-19 pandemic. This has been a significant investment and has resulted in improvements and upgrades which include:

- Modernisation - including showers, bathrooms, medical utilities, office space, the nurse station and nurse call.
- Brighter, energy efficient LED lighting.
- New corridor flooring and refreshed painting, including consideration of colour to meet dementia-friendly requirements.

The works will also include essential fire safety improvements and a deep clean of each ward.

4. Reportable Issues Log

Issues occurring between 21.04.2021 and 20.05.2021

4.1. *Serious Incidents and Never Events*

During this reporting period:

- No never events have been reported.
- 3 incidents have been reported on the Strategic Executive Information System (StEIS). Two of these are from within our maternity department and one relates to a Regulation 28 following a coroner's inquest.

4.2. *Level Four and Five Complaints*

2 level 4 complaints received in the time period both relating to treatment and care.

4.3. *Regulation 28 Reports*

The Trust received a Regulation 28 report on 10 May 2021 from Liverpool Coroner's Court following an Inquest. We are reviewing our inter-Trust referral processes/communication. A response will be provided to the Coroner by 3 July 2021.

5. Media Coverage

- Health leaders hear views of patients, staff and public (Champion newspapers, April 2021)
- Landmark day as Merseyside hospital records zero Covid patients (Liverpool Echo, 30 April)
- Southport and Ormskirk hospitals support volunteers with VIP training (In Your Area, 10 May)
- "Improvement across all domains" at Southport and Ormskirk Hospital - but MP is unconvinced (Lancashire Evening Post, 13 May)
- Elderly man with 'only a blanket wrapped around his bottom half' discharged from hospital (Liverpool Echo, 14 May)
- Nursing students in England and India share learning on Covid-19 (Nursing Times, 14 May)

- Trust praised by health watchdog (print - Southport Champion, 19 May)
- Tragic death of little girl due to missed opportunities at Lancs hospital (Lancs Live, 20 May)

6. Risk Register and Board Assurance Framework

No significant changes to note.

Trish Armstrong-Child
Chief Executive
27 May 2021

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Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB090/21**	**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 20/21 SOF and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator has a Statistical Process Control (SPC) chart and commentary.

Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

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

Recommendation

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

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Michael Lightfoot, Katharine Martin	The Executive Management Team

Activity Summary – April 2021

Indicator Name	April 2019	April 2020	March 2021	April 2021	Trend
Overall Trust A&E attendances	10,248	4,307	8,789	9,027	▲
SDGH A&E Attendances	4,795	2,678	4,525	4,939	▲
ODGH A&E Attendances	2,280	726	1,847	2,003	▲
SDGH Full Admissions Actual	1,045	988	1,382	1,299	▲
Stranded Patients AVG	189	104	148	161	▲
Super Stranded Patients AVG	70	33	41	48	▲
MOFD Avg Patients Per Day	47	23	46	42	▲
DTOC Unconfirmed Avg Per Day	7	-	-	-	
GP Referrals (*Exc. 2WW*)	2,616	1,084	1,923	1,433	▲
2 Week Wait Referrals	707	380	926	866	▲
Elective Admissions	170	31	120	123	▲
Elective Patients Avg. Per Day	6	1	4	4	▲

Activity Summary – April 2021

Southport and Ormskirk Hospital NHS Trust

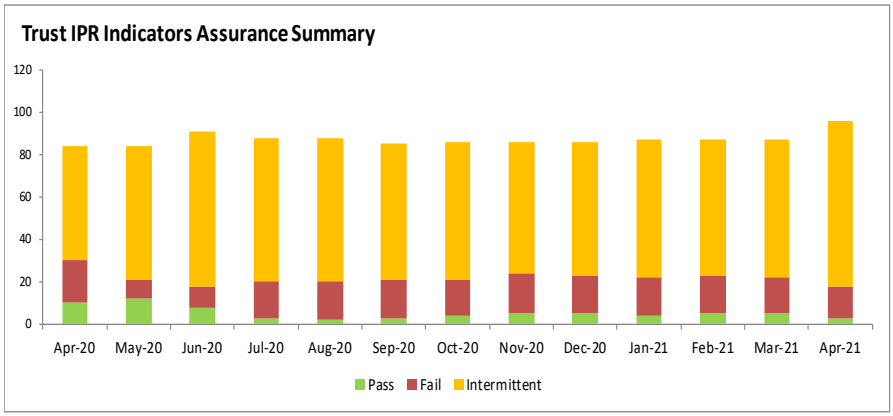
Indicator Name	April 2019	April 2020	March 2021	April 2021	Trend
Elective Cancellations	16	11	18	7	▼
Day case Admissions	1,825	472	1,297	1,243	▲
Day Case Patients Avg. Per Day	61	16	42	41	▲
Day Case Cancellations	45	9	16	17	▲
Total Cancellations (EL & Day Case)	61	20	34	24	▲
Total Cancellations (On or after day of admission, non clinical reasons)	6	2	0	2	
Outpatients Seen	21,874	10,587	22,493	19,314	▲
Outpatients Avg. Per Day	729	353	726	644	▲
Outpatients Cancellations	4,030	9,199	3,981	3,645	▼
Theatre Cases	568	149	354	419	▲
General & Acute Beds Avg. Per Day	No data	457	417	434	▼
Escalation Beds Avg. Per Day	23	5	0	0	▼
In Hospital Deaths	91	147	60	58	▼

Trust Board - Integrated Performance Report

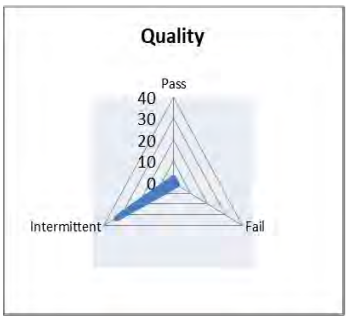
Head of Information Summary

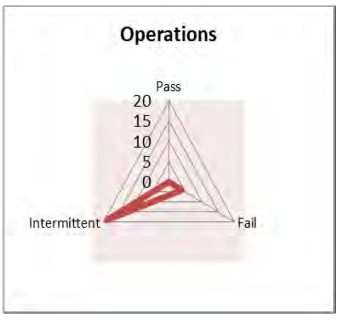
The Board IPR this month includes the changes made as part of the annual review of metrics with the Executive team.

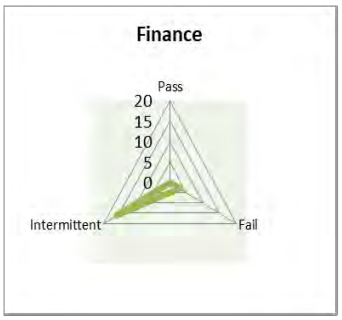
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Pass	10	12	8	3	2	3	4	5	5	4	5	5	3
Fail	20	9	10	17	18	18	17	19	18	18	18	17	13
Intermittent	54	63	73	68	68	64	65	62	63	65	64	65	75

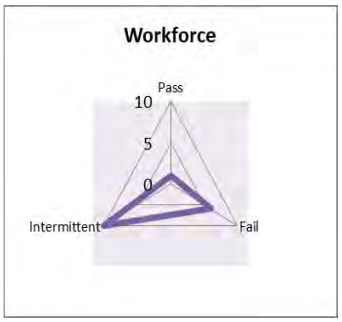


There are 3 indicators which the Board can be assured of: Care Hours per Patient Day; HSMR and Mandatory Training. There are 15 indicators failing to provide assurance however those which the Board need to be alerted to or advised of specifically will be highlighted below.









Within the Quality section (**S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services),* where metrics are presented and reviewed at Quality and Safety Committee, the Board should be alerted to the performance of C-Diff and SHMI. Although C-Diff isn't showing special cause variation its declining performance within month (increase to 59.1 per 100,000 bed days in April from 8.6 in March) is sufficient enough to warrant the inclusion of an action plan to address the reasons for the change. The SHMI assurance is still classed as intermittent however negative special cause variation, with 4 consecutive months performance in excess of the third control limit, is a concerning trend.

The Board should be advised of the Caesarean rates performance which has seen 8 consecutive months above the mean, also the Percentage of Deaths screened in the mortality section which, at 3.3% sees the worst performance since data recording started.

Assurance for Quality comes from the CHPPD and HSMR, in addition a number of indicators which are demonstrating sustained and consistent high performance. Notably Never Events, WHO Checklist, Number of Maternal Deaths and No. Occasions 1:1 care not provided. Both Duty of Candour measures are also now showing consistent performance month on month.

The Operations Section (**S02** – *Deliver services that meet NHS constitutional standards and regulatory standards)* was formally presented to Finance, Performance & Investment Committee (FP&I). Although there are a number of indicators which are failing to provide assurance these are all related to waiting times, the two main waiting times indicators the Board should be alerted to are Diagnostic Waits performance and RTT performance. Both of these have become stable in recent months yet are not achieving target. Supplementary action plans have been provided for both.

The Board should be advised of the 14-day Cancer performance which has failed to meet target for the seventh month in a row and is showing negative special cause variation which indicates that it is not showing signs of an improvement trajectory. There are several indicators related to waiting times which are also showing negative special cause variation, detail behind these is included in the main waiting times action plan.

Despite no indicators showing assurance there are a number which are performing as expected or showing signs of improvement in month. Both stranded patient's metrics are significantly improved in performance compared to pre-Covid-19 levels. Also, ED conversion rate has dropped from 28.4% to 21.9% which is more in line with expected performance against an increased number of attendances.

This month's finance metrics (**S03** – *Efficiently and productively provide care within agreed financial limits*) were also presented to FP&I. There are a number of new indicators which are introduced into the IPR this month, with the absence of historical data no trend analysis can be performed yet.

The Board should be alerted to both the Pay and Non-Pay Run rate measures which are failing to provide assurance and also showing negative special cause variation. Both are showing a significant improvement from the last month though which is a clear outlier.

Advisory notices this month relate to the new indicators which require further historical data to determine both performance and assurance. The Board can also be advised that the Bank & Agency run rate cost has exceeded the mean for the past 6 months.

For assurance in Finance the Board is directed to the % Agency Staff (Cost) which has reduced significantly from a high of nearly 12% in December 2019 to the latest month's performance of 6.3%.

The final section is Workforce (**S04** – *Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated)* which has metrics previously discussed at Workforce Committee.

Alerts in this section include the performance of Personal Development Reviews (PDR's), rolling 12-month sickness rate, and the rolling staff turnover. A supplementary action plan has been provided for additional assurance for PDR's as despite a small increase in month to 73.7% this is still short of the new 85% target. This rolling sickness rate at 6.1% has a 12th consecutive month higher than the average although the last month was a minor improvement.

An advisory notice should be provided for nursing sickness rates, which at 7.9% is significantly above the revised plan of 5% and appears to be stable in performance so no improvement is yet to be made. An action plan has been provided for additional assurance of this measure.

Assurance from Workforce, apart from Mandatory Training performance, is from the Medical and Nursing vacancy rates, with the nursing vacancy rate in particular improving from nearly 25% in February 2021 to 9% in April 2021.

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Integrated Performance Report

Board Report

April 2021

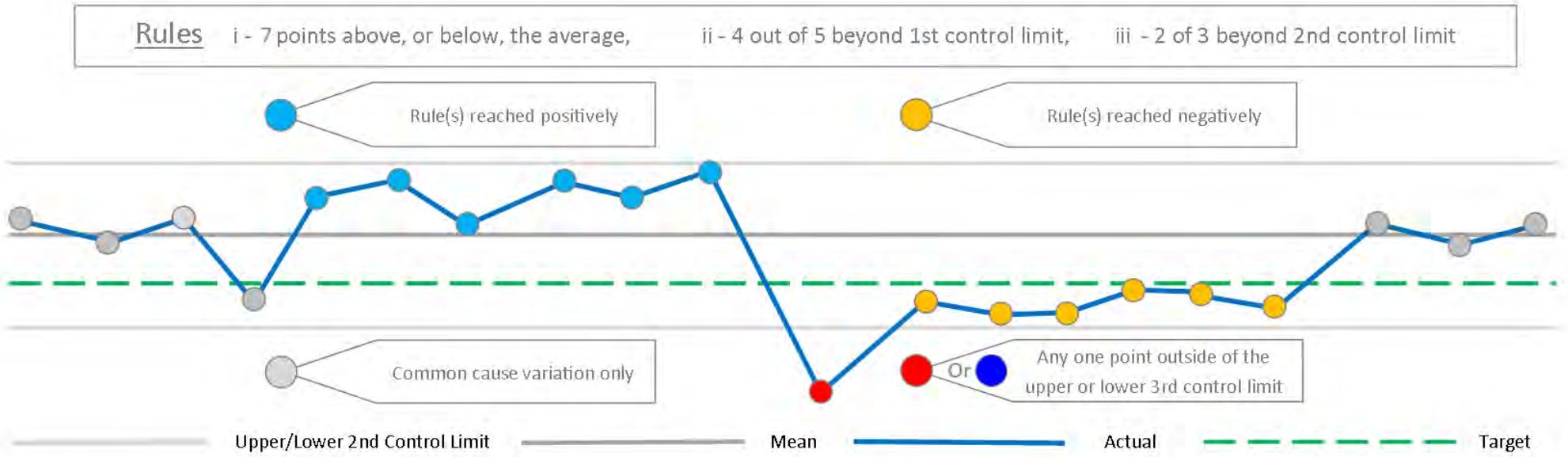
Guide to Statistical Process Control

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	1	10	0	0	1	2	8
	Infection Prevention and Control	0	0	4	0	0	0	0	4
	Maternity	0	0	11	2	0	0	2	7
	Mortality	1	1	2	1	1	0	1	1
	Patient Experience	1	0	6	0	0	3	1	3
Operations	Access	3	0	6	2	2	0	2	3
	Cancer	0	0	3	0	1	0	0	2
	Productivity	1	0	9	1	1	1	2	5
Finance	Finance	2	0	15	3	0	1	1	12
Workforce	Organisational Development	1	1	1	0	1	0	0	2
	Sickness, Vacancy and Turnover	4	0	8	5	0	0	3	4

Assurance

Measures the likelyhood of targets being met for this indicator.

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

Variation (Past 3 Months)

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

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

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

Committee/Group:	QUALITY & SAFETY COMMITTEE (QSC)
Meeting Date:	24 MAY 2021
Lead:	DR DAVID BRICKNELL

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

No Alerts this month.

ADVISE

- The lost to follow up programme is in discussion with the CCG in relation to an outsourced programme funded by them. In the meantime our internal review programme is continuing with currently no reason for an alert.
- Following comments from MIAA and the continuing challenge of reporting to regulatory requirements, a wide-ranging review of the Stroke service is being carried out. Elevating this service to Fragile status is expected to be short term.
- The External Orthopaedic review will be the subject of a report to the Board shortly, together with a more wide-ranging report on hip and knee replacement. The College report will be shared appropriately with external agencies. Duty of Candour has already been addressed.
- Those fragile services risk rated as Extreme have had the risk to patients mitigated, albeit short term, and longer term solutions are being prepared.
- After a moderate spike in C.Diff. last month it appeared there was no common internal theme. However there might be a link to changes in antibiotic prescription during the pandemic as there had been a similar spike elsewhere.
- Whilst the mandated IPC report for the Board showed a very positive outcome to the IPC measuring, the relaxation of the Covid related measures would be cautious, even if they represented a higher than base level cost.
- The Governance report was mainly positive, but the Committee highlighted the need to improve the quality of hand over reports, whether shift, Ward transfers or discharge, and there needed to be more clarity on the lessons learned and implemented.

ASSURE

- The CQC report was essentially very positive, reflecting improvement in all matters reviewed. Unfortunately as it was only a partial investigation it can't reflect on our public rating.
- Despite the lack of guidance on the review of Covid related deaths, internally we have been carrying on with the normal process and have some of the highest rates in the region. The normal reporting will be resumed imminently now that Medical Examiners have been appointed.
- The wide ranging Maternity report gave significant assurance of the governance of our maternity service and the measures being taken to meet national initiatives, both Ockenden and otherwise.
- The Freedom to Speak Up Annual report reflected growing confidence in the efficacy of the programme.

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

Review of the Risk Register

Quality

Harm Free

Analyst Narrative:

Following the IPR review, changes have been made to some of the indicators and targets within this section. This has included the measurement of some indicators by bed days. The number in the 'Patients' column includes the numbers.

No indicators within this section are currently failing their assurance and one is assured; Care Hours per Patient Day (CHPPD). All other indicators are intermittent in their assurance. Never Events, StEIS and WHO Checklist are all currently showing special cause improvement. Although not statistically significant, moderate and above patient falls has exceeded the mean with 2 reported in April.

The targets for both CHPPD and Safe Staffing have been aligned to national targets and the Trust remains ahead of both in month.

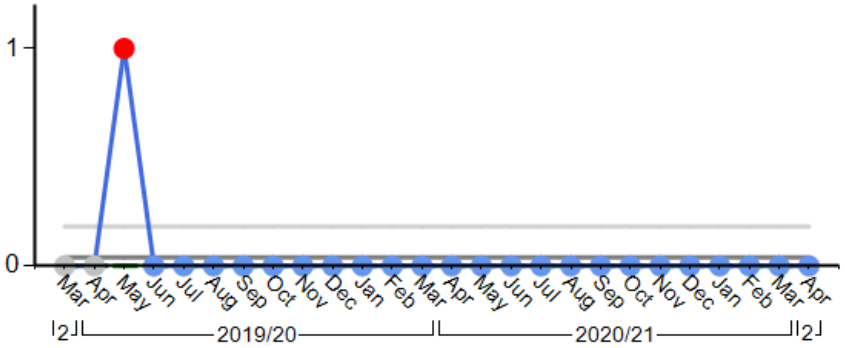
Operational Narrative:

Two of the four category 2 pressure ulcers have been reviewed at Harm Free Care. In one of the two cases, there were no identified lapses. In one case, there were some identified lapses and appropriate action plans are now in place. The remaining two are under investigation and will be presented at Harm Free Care Panel for review.

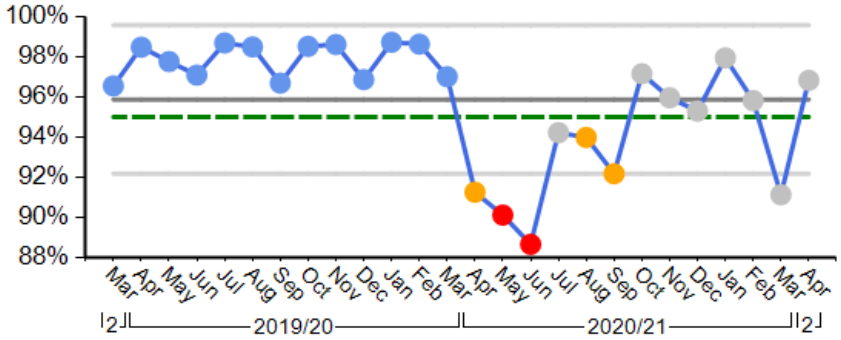
The targets for both CHPPD and Safe Staffing have been aligned to national targets and the Trust remains ahead of both in month.
Care Hours per Patient Day performance remains reflective of previous months reporting at slightly above average (9.0).
We continue to monitor fill rate to ensure we maintain safe staffing daily with April reporting safe staffing at 92.8% against the national target (90%).

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Apr 21		0	0	Mar 21	0	0	
VTE Prophylaxis Assessments	95%	96.8%	120	Apr 21		95%	91.1%	Mar 21	95%	96.8%	
Fractured Neck of Femur - Operated on within 36Hours	85%	82.1%	23	Apr 21		90%	77.8%	Mar 21	85%	82.1%	
WHO Checklist	100%	100%	0	Apr 21		99.9%	100%	Mar 21	100%	100%	
Safe Staffing	90%	92.8%	N/A	Apr 21		95%	90%	Mar 21	90%	92.8%	
Care Hours Per Patient Day (CHPPD)	7	9	N/A	Apr 21		7.9	9.5	Mar 21	7	9	
StEIS	0	2	2	Apr 21		0	1	Mar 21	0	2	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.3	4	Apr 21		0.5	0.2	Mar 21	0.45	4	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0	0	Apr 21		0.1	0	Mar 21	0.1	0	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	1.2%	6	Apr 21		2.1%	0.9%	Mar 21	2.1%	1.2%	
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.2	2	Apr 21		0.1	0.2	Mar 21	0.1	0.2	

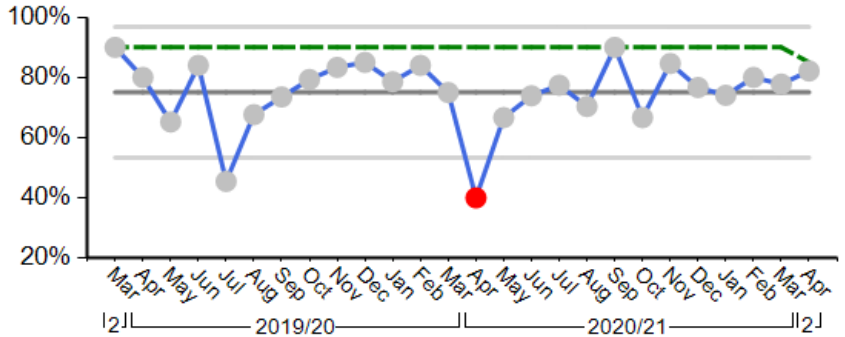
Never Events



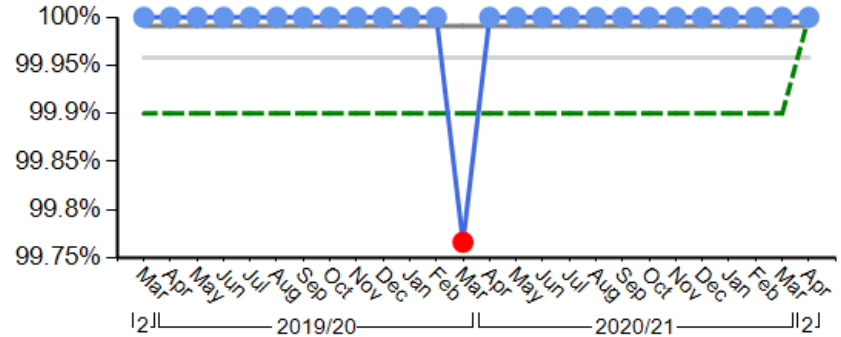
VTE Prophylaxis Assessments



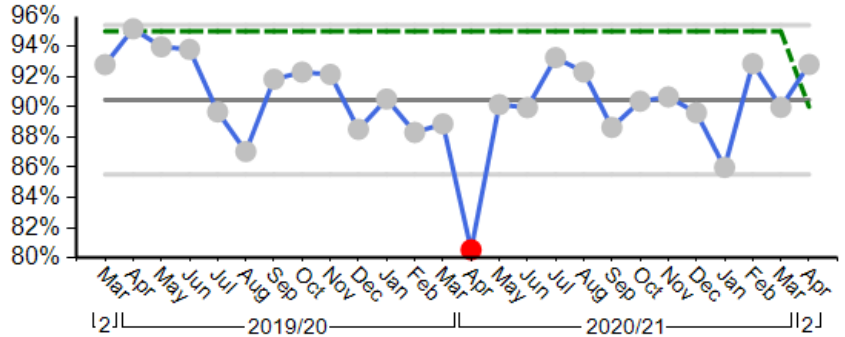
Fractured Neck of Femur - Operated on within 36Hours



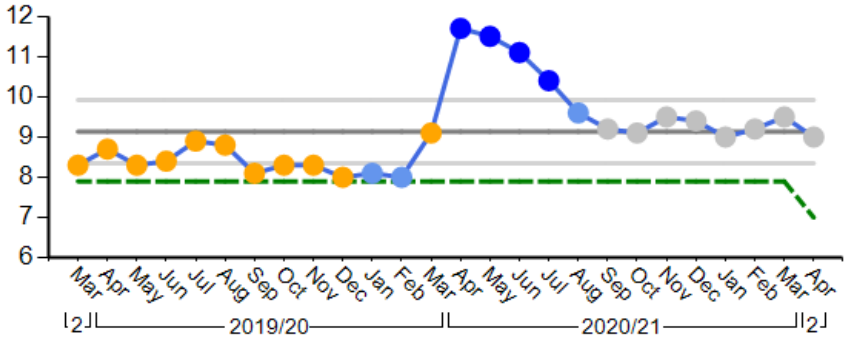
WHO Checklist



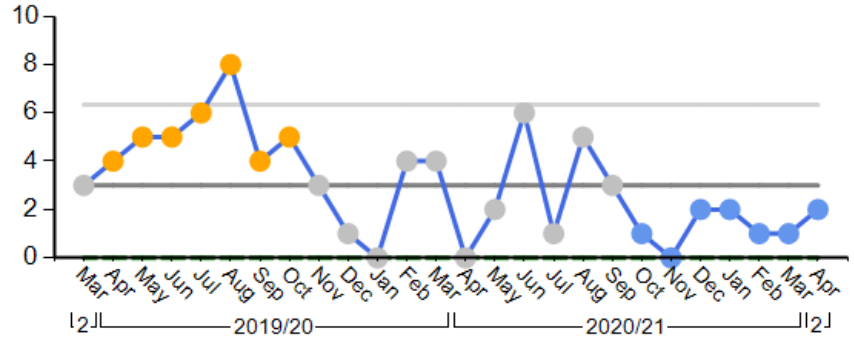
Safe Staffing



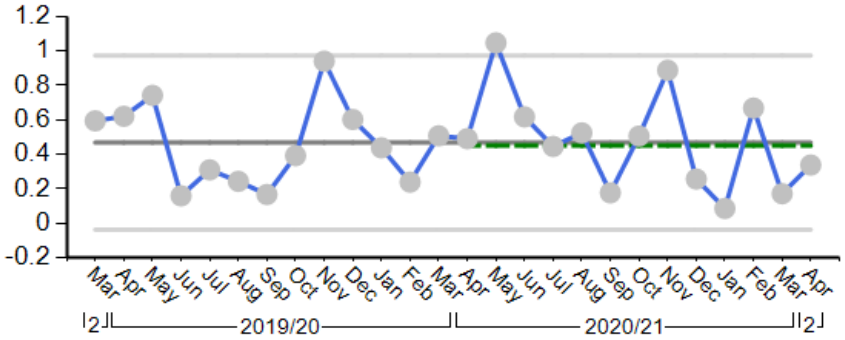
Care Hours Per Patient Day (CHPPD)



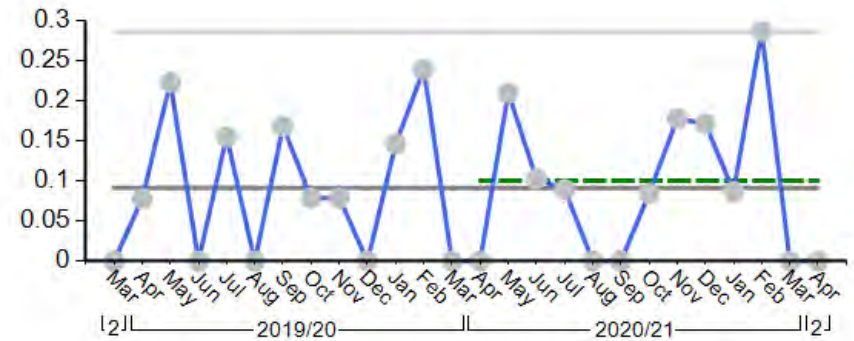
StEIS



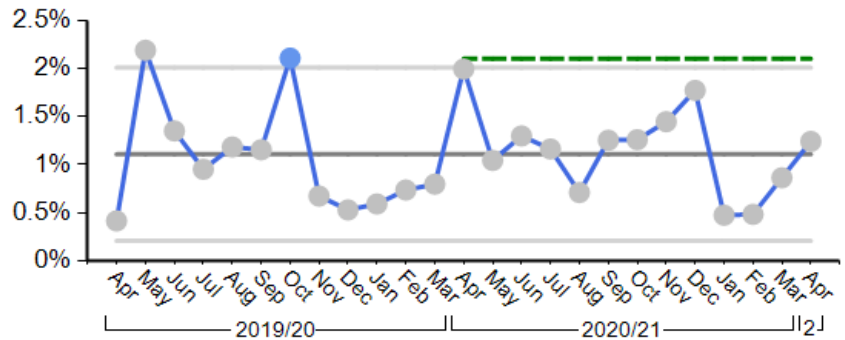
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



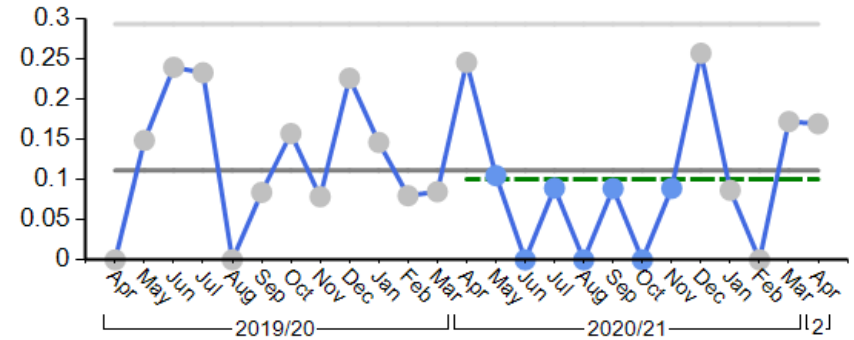
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



Percentage of Patient Safety Incidents - Moderate/Major/Death (related)



Patient Falls - Moderate/Severe/Death - per 1,000 bed days



Quality

Infection Prevention and Control

Analyst Narrative:

With the exception of MRSA, all indicators within this section have been amended to report per 100,000 bed days, against benchmark data from the Public Health England Epidemiological commentary from June 2019 – May 2020 with data back dated.

Rates of c.diff infection have increased in April and have breached the 2nd upper control limit. This relates to 7 reported cases. Performance on all other indicators remains intermittent.

Operational Narrative:

No cases of MRSA reported in April.

7 cases of hospital acquired C. diff. Ribotyping of 6 samples all dissimilar inferring no transmission where there has been more than 1 case on a ward.

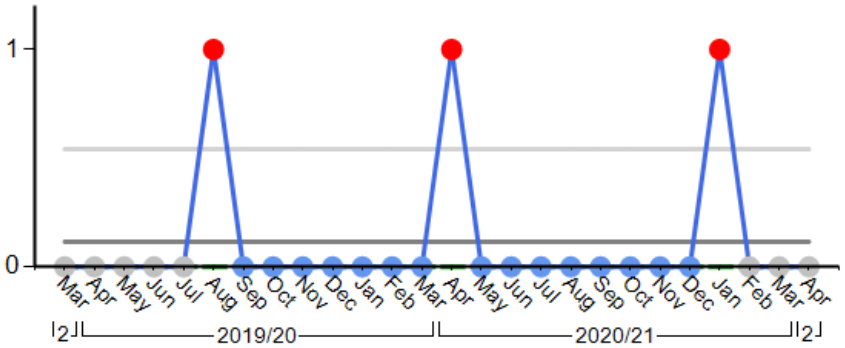
All reported hospital acquired c.diff infections have been investigated. 4 identified no lapses in care. Lapses in care in the other 3 cases related to antibiotic prescribing, delays in isolating and delay in ordering sample. An action plan relating to c.diff is included.

3 cases of hospital acquired E coli were reported. All have been investigated with no apparent lapses in care.

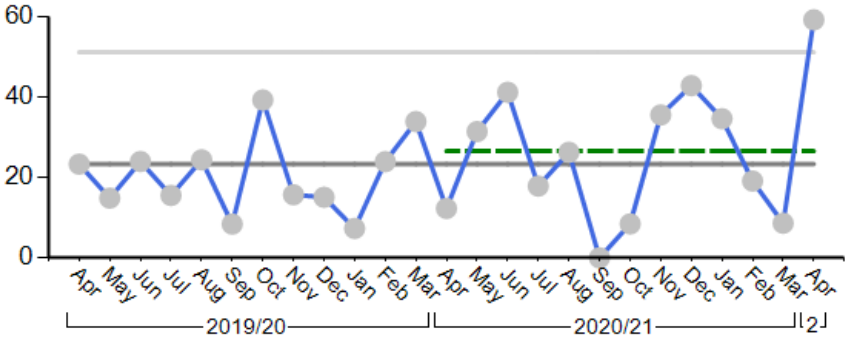
No cases of hospital acquired MSSA reported.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Apr 21		0	0	Mar 21	0	0	
Clostridium Difficile - per 100,000 bed days	26.5	59.1	7	Apr 21		26.5	8.6	Mar 21	26.5	59.1	
E. Coli - per 100,000 bed days	20.6	25.3	3	Apr 21		20.6	25.8	Mar 21	20.6	25.3	
MSSA - per 100,000 bed days	8.8	0	0	Apr 21		8.8	0	Mar 21	8.8	0	

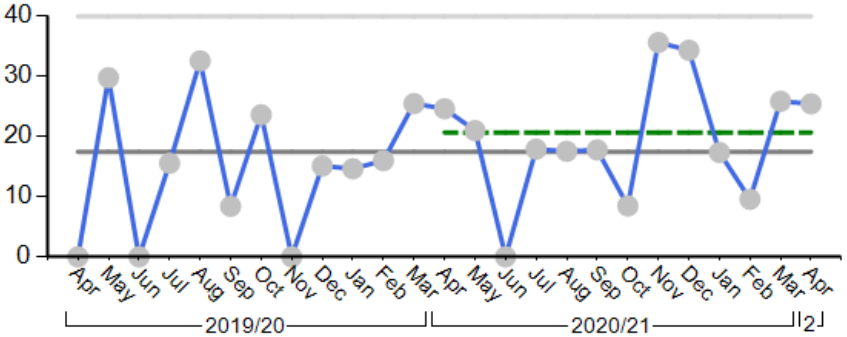
MRSA



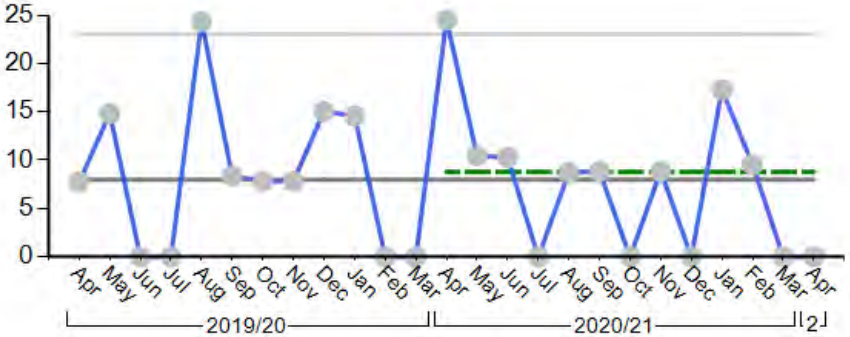
Clostridium Difficile - per 100,000 bed days



E. Coli - per 100,000 bed days



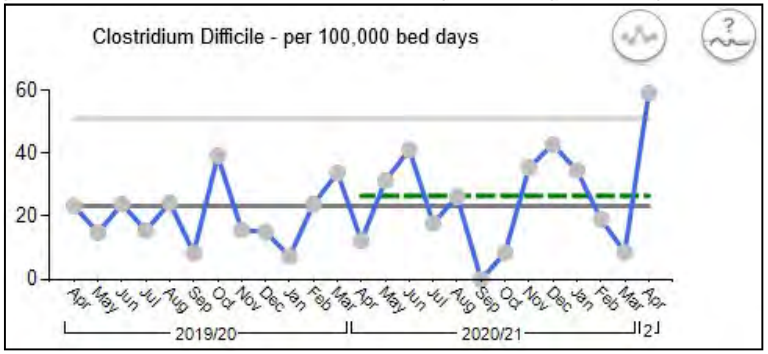
MSSA - per 100,000 bed days



Clostridium Difficile

NHS
Southport and Ormskirk Hospital
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Clostridium Difficile - per 100,000 bed days	26.5	59.1	N/A	Apr 21		26.5	8.6	Mar 21	26.5	59.1	



Background: The rates of clostridium difficile infections per 100,000 bed days. The target is 26.5 based on PHE epidemiological commentary Jun 2019—May 2020.

Situation: Performance on this indicator has been intermittent over the last few months. There has been an increase in cases (7) in April but this is not statistically significant.

Issues:

3 of the 7 cases identified lapses in care relating to:

Delays in isolation/issues with documentation relating to the decision to not isolate.

Antibiotic prescribing— prescribing without a written indication and not in line with Trust guidelines. Also issues with the appropriateness of the choice of antibiotic.

Delay with testing to confirm presence of c.diff infection.

Actions:

All reported hospital acquired cases of c.diff are subject to an RCA process.

A Trust C. diff action plan has been developed.

A bronze IPC meeting meets twice a week to review actions and promote plans.

The CCG is included in the Bronze meeting and there is joint working across the 2 CCGs and the hospital with respect to antimicrobial prescribing and the possible use of Pre/pro-biotics.

Notifications have gone to doctors and nurses through e-mail, Trust News and hand delivered laminated guidance/poster to all the wards with respect to isolation, sampling and antibiotics prescribing.

Updates to the current treatment of sepsis of unknown origin is being reviewed and updated through the clinical leads.

Stool samples from any patients on wards where there has been possible transmission have been submitted for ribotyping – the results of these samples are that they are all different therefore transmission between these patients has not occurred.

Mitigations:

All the wards are being cleaned with sporicidal disinfectants. In addition vacated C diff side rooms are fogged using hydrogen peroxide vapour.

The Antimicrobial pharmacist is engaged in weekly antimicrobial ward rounds as well as audits.

The ARK (Antibiotic Review Kit) prescription sheets are being continued throughout the trust – this prompts for not only indication but also for 72 hour review.

Sporicidal disinfection wipes to be used for all commode cleans – currently these are used just for equipment that has been used on a C diff positive patient.

IPC training provided to all affected wards regarding C diff.

Quality

Maternity

Analyst Narrative:

Following the IPR review, the new targets have been implemented from this month. These targets are based on benchmarking data from the Regional dashboard, Model Hospital and NHS Digital.

Currently, no indicators are assured, but equally none are failing as performance on all indicators is intermittent. Caesarean rates shows special cause concern despite the re-based target, with a significant increase in April. An increase in induction rate is also noted, although this remains within control limits.

Maternity complaints, now measured as a percentage of deliveries, is showing special cause concern due to the spike in March (5 received), this has reduced in April and is below plan.

Following increases in March, no neonatal deaths or stillbirths were reported in April. The number of Occasions 1:1 Care was not provided continues to show special cause improvement, achieving 0 for the last 18 months.

Operational Narrative:

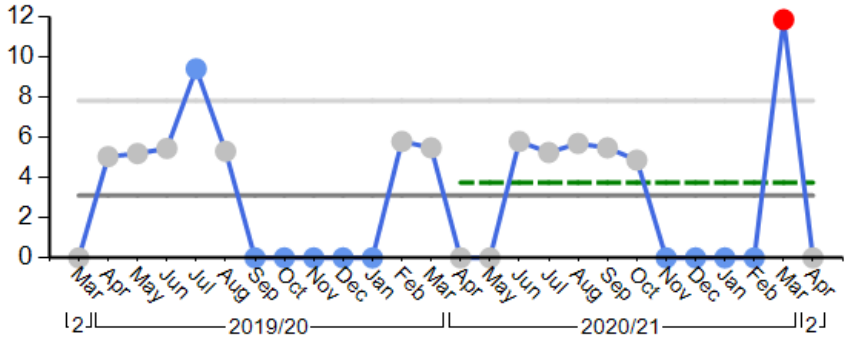
The caesarean section rate and induction rates increased in April. An audit of induction of labour for large for gestation age babies has been undertaken and a local guideline to support practice in the absence of national guidance has been developed. Further audits are planned to review inductions for reduced foetal movements. These will be presented through PIDA and reported into Clinical Effectiveness Committee. The team will continue to review regional dashboard data to compare performance with peers.

The number of complaints has reduced in April following the spike in March. Themes within the complaints received included pain relief. The Unit is implementing real time patient feedback to ensure women feel safe and well cared for at all times.

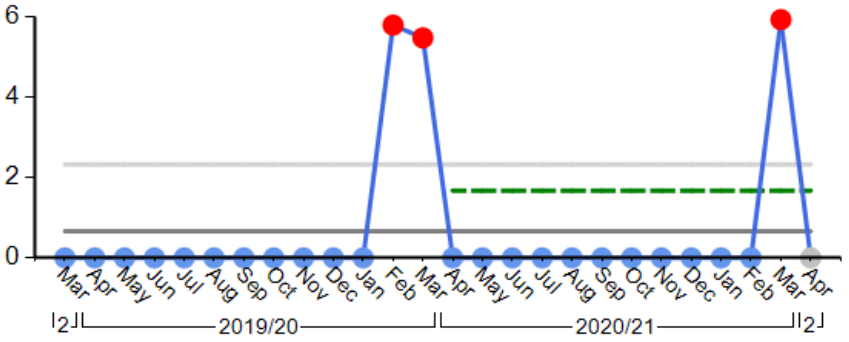
There was one maternal incident reported as a Serious Incident on STEIS in April related to a Still Birth. The incident is being investigated.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Stillbirth Rate (per 1,000 births)	3.74	0	0	Apr 21		3.7	11.8	Mar 21	3.74	0	
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Apr 21		1.7	5.9	Mar 21	1.67	0	
Number of Maternal Deaths	0	0	0	Apr 21		0	0	Mar 21	0	0	
Caesarean Rates	28.5%	37.3%	62	Apr 21	H	24%	32.3%	Mar 21	28.5%	37.3%	
Induction Rate	38%	48.2%	80	Apr 21	L	33.3%	42.5%	Mar 21	38%	48.2%	
Breastfeeding Initiation	62%	65.8%	54	Apr 21		60%	64.8%	Mar 21	62%	65.8%	
Percentage of Women Booked by 12 weeks 6 days	90%	93%	14	Apr 21		90%	92.6%	Mar 21	90%	93%	
Number of Occasions 1:1 Care Not Provided	0	0	0	Apr 21	L	0	0	Mar 21	0	0	
Maternity Complaints as % of Deliveries	0.7%	0.6%	1	Apr 21	H	0.7%	3%	Mar 21	0.7%	0.6%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	0.7%	1	Apr 21		3%	2%	Mar 21	1.5%	0.7%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	9.1%	2	Apr 21		6%	0%	Mar 21	11%	9.1%	

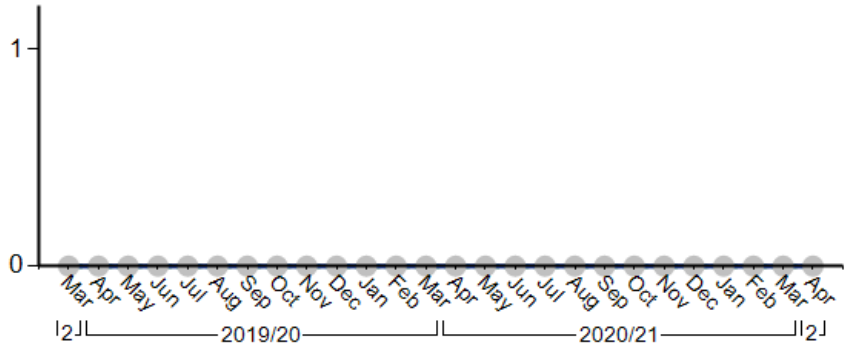
Stillbirth Rate (per 1,000 births)



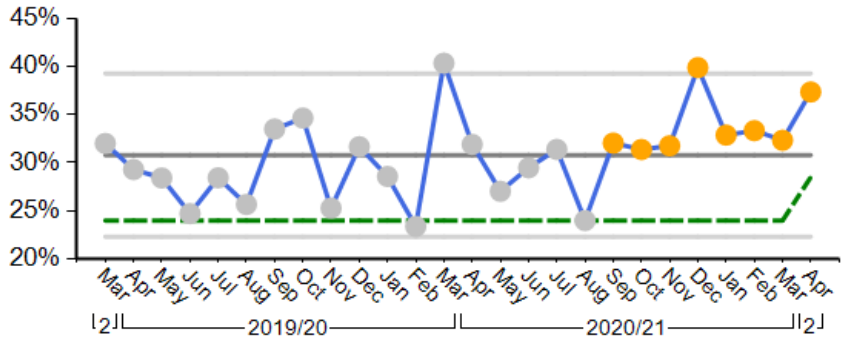
Neonatal Mortality Rate (per 1,000 births)



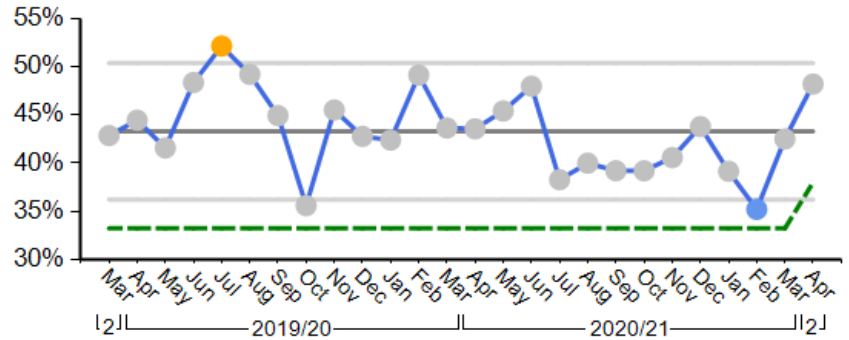
Number of Maternal Deaths



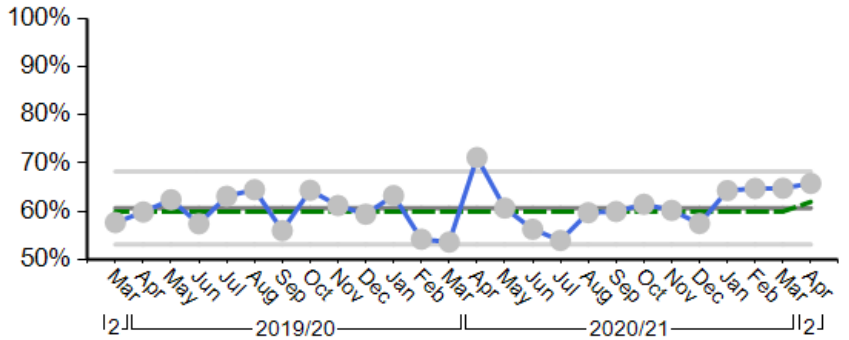
Caesarean Rates



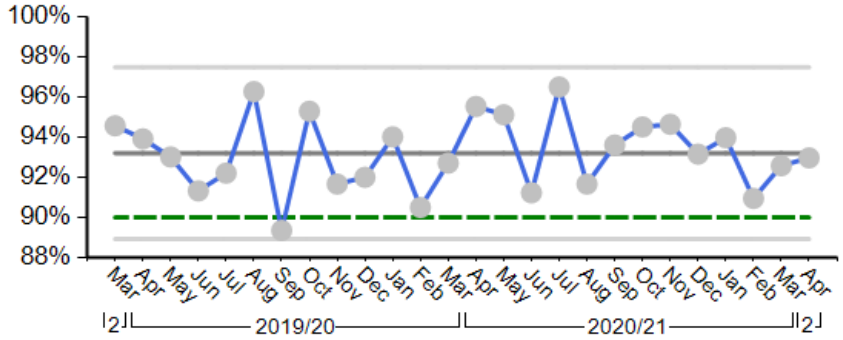
Induction Rate



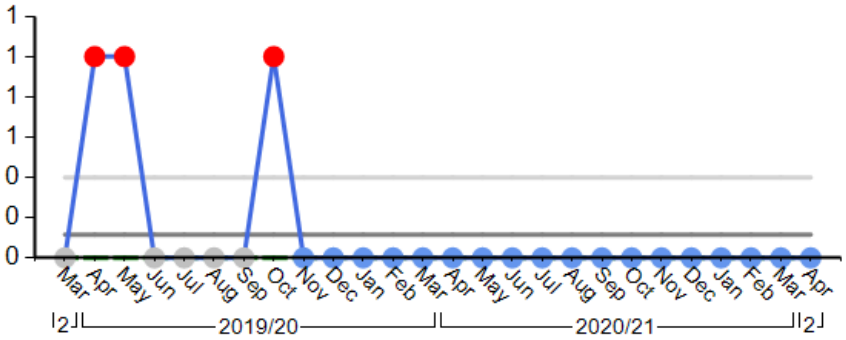
Breastfeeding Initiation



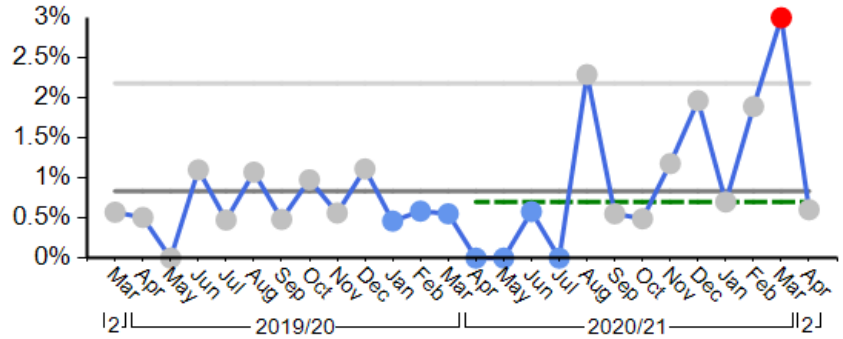
Percentage of Women Booked by 12 weeks 6 days



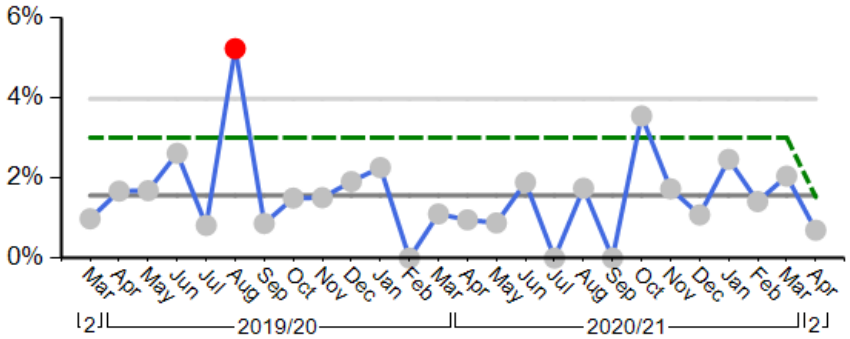
Number of Occasions 1:1 Care Not Provided



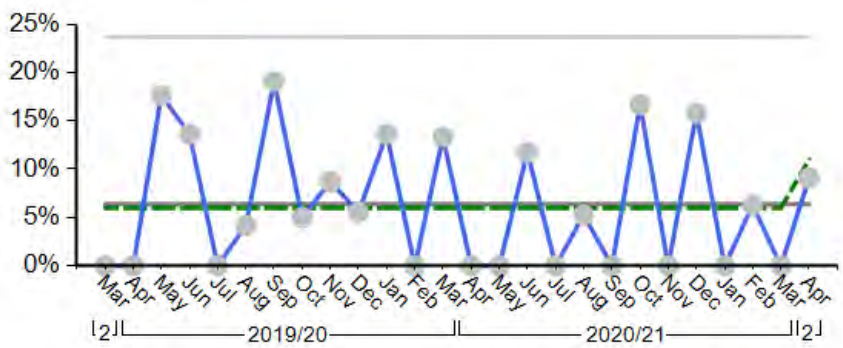
Maternity Complaints as % of Deliveries



Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births



Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births



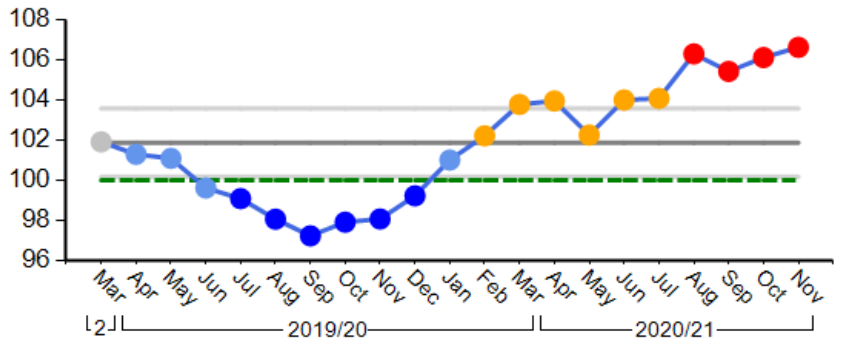
Quality

Mortality

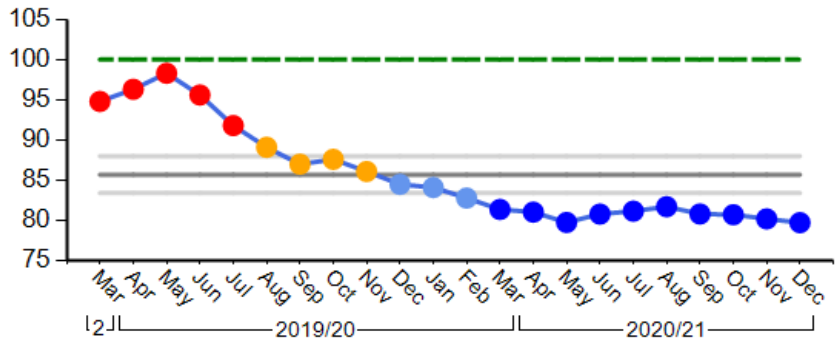
The latest SHMI, for the 12 month period ending November 2020 is 106.6, which is a small increase from the previous month. In the 12 month period ending October 2020 there are 2% of spells (770 spells) excluded from mortality reporting due to Covid. HSMR continues to show positive variation, which in conjunction with the SHMI demonstrates how the out-of-hospital deaths are driving this figure. The perinatal mortality rate (now with a revised plan in line with the MBRRACE Report 2017) is 0 this month following the spike in March. The Mortality Screening performance declined further in March to just 3.3%, continuing the poor performance seen since the start of Covid. This will increase when the Medical Examiner's Officer commences in post.
Please also refer to the supplementary action plan for SHMI.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	106.6	N/A	Nov 20		100	106.1	Oct 20	100	104.8	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	79.7	N/A	Dec 20		100	80.2	Nov 20	100	79.7	
Percentage of Deaths Screened	100%	3.3%	58	Mar 21		100%	13.3%	Feb 21	100%	20.2%	
Perinatal Mortality Rate	5.4	0	0	Apr 21		7.7	17.9	Mar 21	5.4	0	

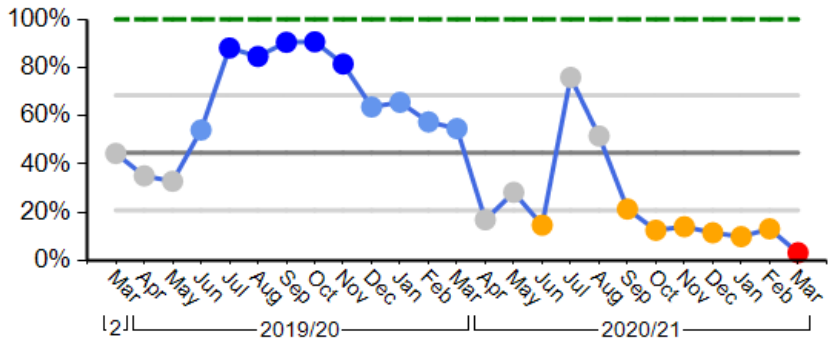
SHMI (Summary Hospital-level Mortality Indicator)



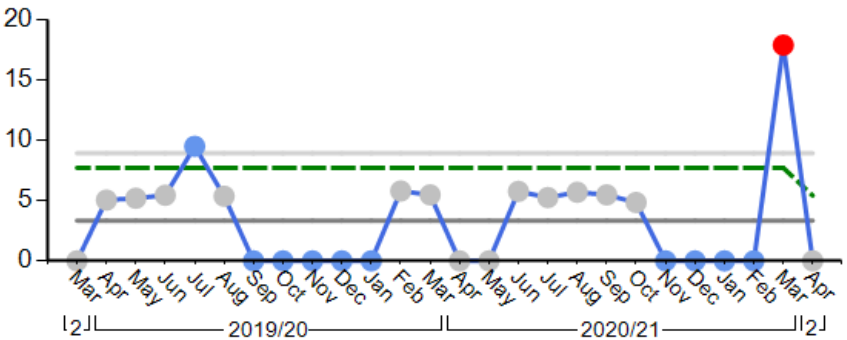
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



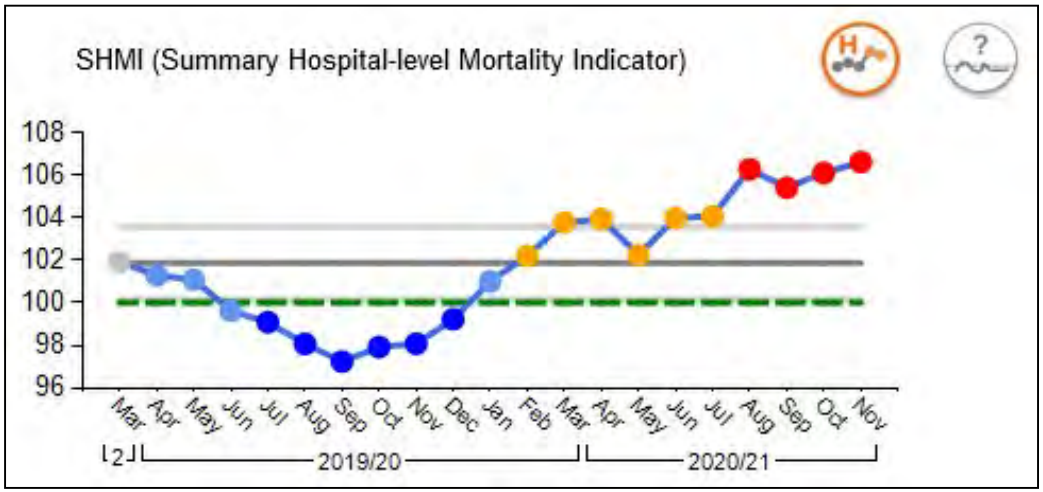
Perinatal Mortality Rate



SHMI (Summary Hospital-level Mortality Indicator)

NHS
Southport and Ormskirk Hospital
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
SHMI (Summary Hospital-level Mortality Indicator)	100	106.6	N/A	Nov 20		100	106.1	Oct 20	100	104.8	



Background: The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge**.**

Situation: This indicator has been on a deteriorating trajectory since the start of the Covid pandemic. For the last 4 months, performance has breached the 3rd upper control limit.

Issues:

As a rolling 12 month value, each new month includes an extra month of Covid related exclusions. With each new month of Covid exclusions included the number of expected deaths has decreased.

The decline in SHMI is largely a result of the out of hospital rate, which is more a reflection of the decrease in the number of expected out of hospital deaths rather than an increase in the number of observed out of hospital deaths.

For out of hospital deaths, it is a challenge to understand whether the cause of death related to the patients reason for admission.

Actions:

MOG to continue to review diagnosis groups which show an elevated SHMI for accuracy and understanding of the clinical situation.

14 Diagnosis Codes per Episode are currently sent with our Commissioning Data Set (CDS) return, we are investigating increasing this to 25.

To work more closely with GP's to highlight out of hospital deaths using Mortality Operational Group data and work to understand the causes.

Mitigations:

Monthly SHMI data is discussed at Mortality Operational Group.

The Trust utilises Structured Judgement Reviews for deaths which trigger for review, with all learning fed back through specialty meetings.

The Trust continues to monitor its internal mortality rate through a crude and excess death rate, both of which are showing assurance with the only statistical variation coming from the Covid waves.

Quality

Patient Experience

Analyst Narrative:

Delivering Same Sex Accommodation continues to fail its assurance measure. This is based on historical performance with the number of breaches reported in April the same as previous month and all related to delayed discharges from Critical Care.

Duty of Candour continues to show special cause improvement, maintaining 100% performance. The Friends and Family Response rate has been added this month, and is showing special cause improvement with continued performance in excess of the 2nd upper control limit. Whilst not statistically significant, Friends and Family Test - Patients - % That Would Recommend - Trust Overall has declined further, this requires additional narrative.

Operational Narrative:

The Delivering Same Sex Accommodation breaches continue to be escalated at the 3 x daily bed meetings.

The proportion of complaints closed within 40 days has increased due to a continued focus by the CBU Teams, but 7 complaints failed to achieve this timescale. The Complaints Review Group, chaired by the Director of Nursing, continues to meet weekly to understand any delays. This is supported by weekly reporting from the Corporate Team.

The Trust overall Friends and Family response rate is at 24.96% for April 21. Women and children's overall response rate and recommendation rate has increased in month which is excellent.

A further Senior Nurse Walkabout is planned for the end of May beginning of June, to speak to patients regarding their experience of being hospitalised. The detail of this exercise will be reported at the PECE Group and Trust Board.

Maternity % that would recommend service 88.9% - QR codes and posters put up around clinical areas to encourage response. Service has also introduced patient experience engagement initiatives to get real time feedback.

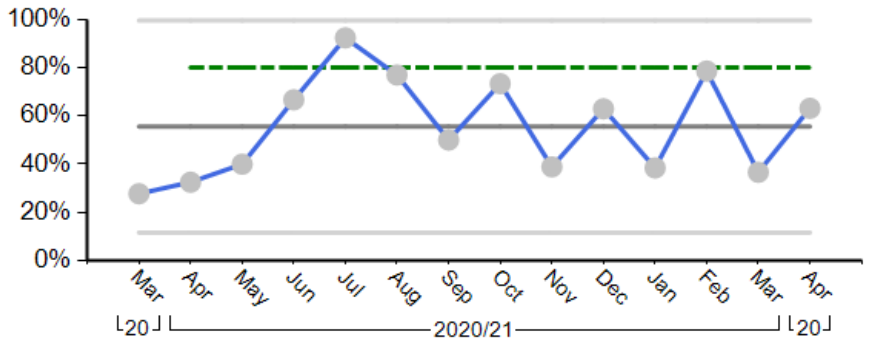
Planned care - FFT response rate for this CBU is at 33% with 600 respondents and 95% of patient would recommend the service. Outpatient feedback is 99.02 % positive based on 1581 text respondents.

Urgent care – overall FFT response rate has remained the same however there are hot spots of areas where performance in recommendation is poor- the wards have been asked as part of their action plans for the ward performance reviews to consider with their Matrons how they will improve both response rate and outcome - a request for cards to be used again has been submitted to IPC awaiting feedback as these were easier for many of our patients to use and complete. The FFT performance in month is to be shared at the next ward performance review.

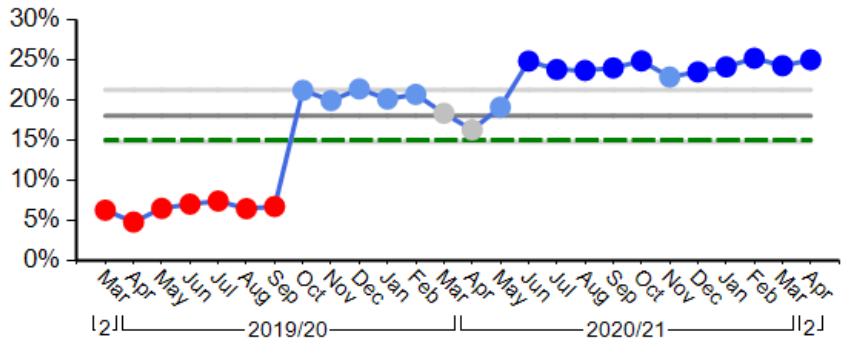
The Patient Experience Conference is in the diary for June 2021 to celebrate the many successes at the Trust.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	63.2%	N/A	Apr 21		80%	36.7%	Mar 21	80%	63.2%	?
Friends and Family Test - Patients - % Response Rate	15%	25%	5260	Apr 21	H	15%	24.2%	Mar 21	15%		?
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	89.8%	178	Apr 21		94%	91%	Mar 21	94%	89.8%	?
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall	83%	NTR	N/A	Apr 21		83%	NTR	Mar 21	83%	58.4%	?
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	4	4	Apr 21	L	0	4	Mar 21	0	4	F
Duty of Candour - Evidence of Discussion	100%	100%	0	Apr 21	H	100%	100%	Mar 21	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Apr 21	H	100%	100%	Mar 21	100%	100%	?

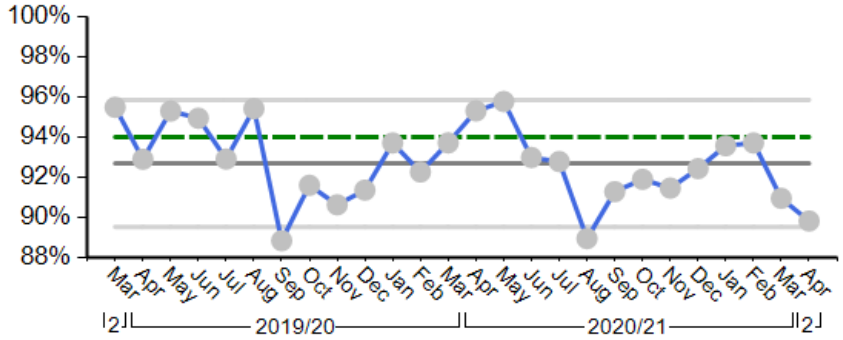
Complaints - % closed within 40 working days



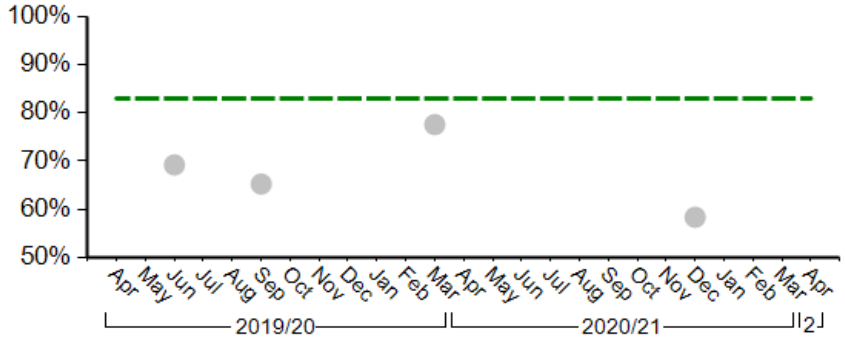
Friends and Family Test - Patients - % Response Rate



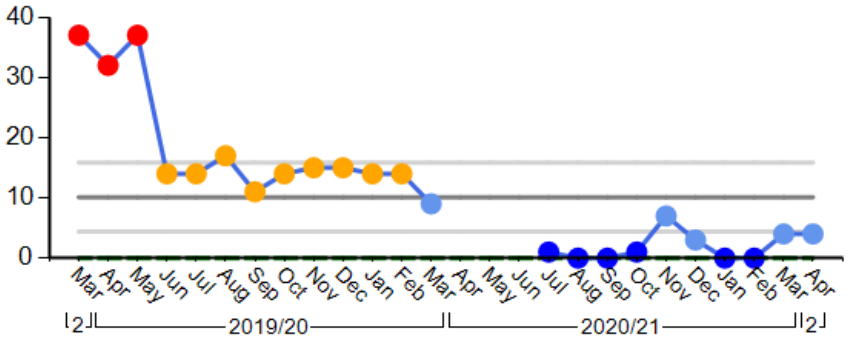
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



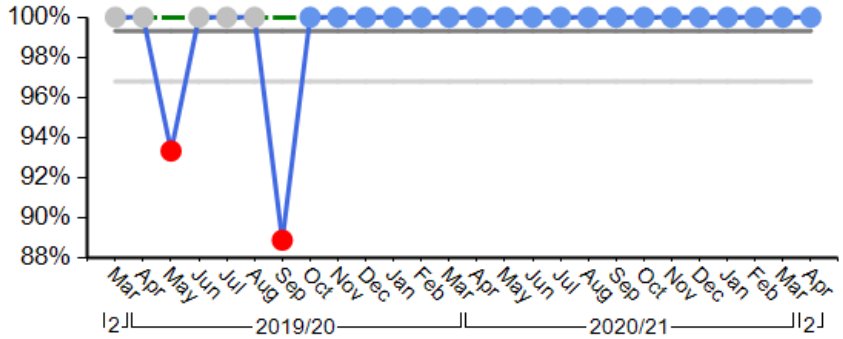
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall



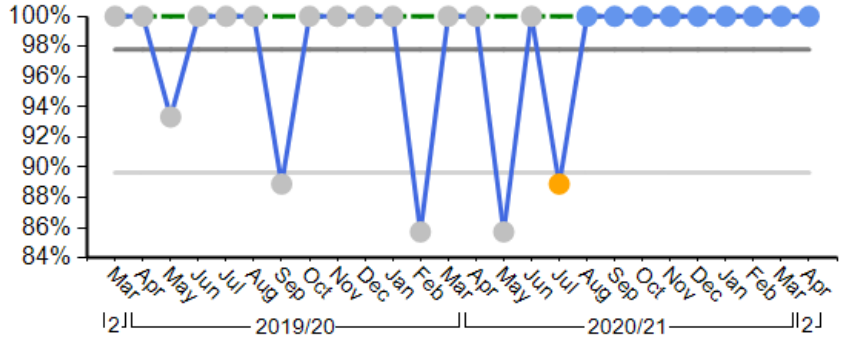
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 JUNE 2021**
Agenda Item	**TB091/21**	**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, IPC		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

This report provides the Board with an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Assurance Framework

Executive Summary

The IPC AF was first reported to the Board in July 2020 and is now presented to Quality & Safety Committee and Board monthly. In addition, NHSE/I have introduced the '*10 Key actions: Infection Prevention and Control and Testing*' document, a summary version of the full IPC AF. A reporting template to monitor compliance, is presented to Silver and Gold Command on a regular basis.

Since the last report, for ease of review we have taken out the previously agreed BLUE / Completed Actions. To ensure these BLUE actions remain embedded and sustained the framework will be regularly revisited to monitor progress and mitigation regarding gaps and compliance against any new or amended guidance. The latest version of the IPC BAF shows that we have moved another action to BLUE, leaving three actions remaining Green / Progressing on schedule.

Progress

The area that has moved to BLUE following improvements includes:

- The IPC team are now monitoring on the Perfect ward IPC audit in-patients wearing face masks.

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

1. Hand Hygiene Audits - Trust compliance April 2021 (**97.5%)** ↑ above target
2. PPE Compliance Audits - Trust compliance April 2021 (**94.9%)** ↑ above target
3. IPC Mandatory Training - Compliance –
    a. Level 1 April 2021 (**92.12%)** ↑ above target
    b. Level 2 training April 2021 **(79.25%)** ↓ **below** target

Areas requiring further improvement.

- Improving IPC Level 2 Mandatory Training – Targeting staff who have not yet completed level two training.
- Storage of Clinical Waste – Work is nearing completion of new waste cupboards allowing improved segregation and storage, due to be completed May 2021.
- Consistency of staff allocation & restricted movement of staff between different areas – we are minimising staff movement between areas, however due to current vacancies this is not always possible.

Recommendations

Southport and Ormskirk Hospital NHS Trust

The Board is asked to **receive** and **note** progress in relation to measures within the Infection Prevention and Control (IPC) Board Assurance Framework.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	✓ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
☐ **SO3** Efficiently and productively provide care within agreed financial limits	
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Andrew Chalmers	Bridget Lees

Publications approval reference: 001559

Infection prevention and control board assurance framework

February 12, 2021. V1.6
Updates from V1.5

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 (April 21)	New BRAG Rating (May 21)
• **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 • 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. Process in place to monitor any positive staff and report to track and trace.	None	None		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• **Training in IPC standard infection control and transmission-based precautions are provided to all staff**	• IPC Mandatory Training - Compliance – Level 1 April 21(**92.12%)** – Target achieved and slight increase on previous month (**91.32%)**. • Level 2 training April 2021 **(79.25%)** – below target but a slight increase on previous month (**78.81%**) • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • Online You Tube training	Not reached 85% target for Level 2 IPC training in April 2021	Monthly training compliance report is circulated to CBUs monthly. 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; including ad-hoc training on the wards by the IPC team – recent ward based training included MRSA, C diff and hand hygiene		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• **IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training**	• IPC Mandatory E-Learning Training has been reviewed and Covid-19 IPC measures are included • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • Links to additional Online You Tube training available	None	None		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• **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**	• Donning and Doffing is part of induction and mandatory training. • IPC Mandatory Training - Compliance – Level 1 April 21(**92.12%)** – Target achieved and slight increase on previous month (**91.32%)**. • Level 2 training April 2021 **(79.25%)** – below target but a slight increase on previous month (**78.81%**) • Most recent PPE audit demonstrates a high compliance rate with PPE compliance - end April 2021 (**94.9%** which is a slight decrease on Mar 2021 97.2%) • Fit Testing – CBUs have processes in place to ensure all patient facing staff have received fit test training to a currently available FFP3 respirator	None	None		

	• IPC Team complete clinical IPC ward rounds on a daily basis (including weekends) promoting PPE compliance and providing instruction as required • Since June 2020 (when all staff were required to wear face masks) 'wearing face mask correctly' posters has been provided through Trust news and posters around hospital • All corporate staff required to wear face masks at desks in CMO and these are provided by the Trust at all access points with hand gel and signs indicating how to put the masks on safely.				

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

No outstanding Actions – all complete

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

No outstanding Actions – all complete

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

No outstanding Actions – all complete

5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**BRAG Rating (April 21)**	**New BRAG Rating (May 21)**
• **Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)**	• Staff 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) • The IPC audit compliance through the Perfect Ward IPC Audit for each ward – this is a new audit that has just been introduced; early results confirm that 100% of mobile in-patients wear a mask				

6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**BRAG Rating (April 21)**	**New BRAG Rating (May 21)**
• 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	• Donning and Doffing is part of induction and mandatory training. • IPC Mandatory Training - Compliance – Level 1 April 21(**92.12%)** – Target achieved and slight increase on previous month (**91.32%)**. • Level 2 training April 2021 **(79.25%)** – below target but a slight increase on previous month (**78.81%**)	None	None		

	• Most recent PPE audit demonstrates a high compliance rate with PPE compliance - end April 2021 (**94.9%** which is a slight decrease on Mar 2021 97.2%) • Fit Testing – CBUs have processes in place to ensure all patient facing staff have received fit test training to a currently available FFP3 respirator. • IPC Team complete clinical IPC ward rounds on a daily basis (including weekends) promoting PPE compliance and providing instruction as required • Since June 2020 (when all staff were required to wear face masks) 'wearing face mask correctly' posters has been provided through Trust news and posters around hospital • All corporate staff required to wear face masks at desks in CMO and these are provided by the Trust at all access points with hand gel and signs indicating how to put the masks on safely.				

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• a record of staff training is maintained	• Yes mandatory training compliance is recorded on ESR and reported monthly Fit Testing – CBUs have processes in place to ensure all patient facing staff have received fit test training to a currently available FFP3 respirator. Training records in relation to Donning & Doffing training is now recorded on ESR as it's now part of the Induction and Mandatory Training. Fit Testing compliance is monitored via the PMO	None	N/A		

7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• **restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other**	• COVID-19 pathways in place. On admission patients are assigned to a covid zone (red, amber green). Green areas are on the Ormskirk site, amber areas are paediatrics, maternity and emergency surgery and medicine wards. Red areas are wards with covid positive	None	N/A		

patients/individuals, visitors or staff	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 • To be reviewed during surge periods				

8. Secure adequate access to laboratory support as appropriate

No outstanding Actions – all complete

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• 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.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (April 21)	New BRAG Rating (May 21)
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• Fit Testing – CBUs have processes in place to ensure all patient facing staff have received fit test training to a currently available FFP3 respirator • 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 (April 21)	New BRAG Rating (May 21)
• 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		

Completed
Progressing on schedule
Slightly delayed and/or of low risk
Significantly delayed and/or of high risk

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**2 JUNE 2021**
Agenda Item	**TB092/21**	**FOI Exempt**	**NO**
Report Title	**CQC UPDATE**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Simon Regan, Deputy Director of Quality, Risk and Assurance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To provide an update on the unannounced inspection and other engagement with CQC.

Executive Summary

The Care Quality Commission (CQC) carried out an unannounced focussed inspection at the Trust on 3 March 2021. As they did not inspect all of the key lines of enquiry, they were unable to make any changes to ratings and all ratings remain unchanged from those issued in November 2019.

The report demonstrates the hard work staff have put in to make improvements and it's extremely positive to note that CQC saw that '*During this inspection on the wards visited there was an improvement across all assessed domains'*.

It's also positive to note that there were no 'must do' actions or breaches of regulation identified. There were seven actions CQC recommend we 'should do' to prevent the Trust from failing to comply with legal requirements in the future.

As a result of the inspection, we are reviewing the full report and current position alongside the 2019 action plan to determine the status of the outstanding actions and will provide a full update at the next Board of Directors meeting.

Recommendations

The Board of Directors are asked to note the outcome of the inspection.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Simon Regan	Bridget Lees

Southport and Ormskirk Hospital NHS Trust

Care Quality Commission (CQC) Update – May 2021

1. BACKGROUND

1.1. The Care Quality Commission (CQC) carried out an unannounced focussed inspection at the Trust on 3 March 2021.

1.2. The CQC inspected the Southport site on Wednesday 3 March 2021 and focussed on the Medicine Core Service. The team, consisting of five inspectors based themselves on site and spent time on the wards meeting with staff, patients, and senior managers.

1.3. At the commencement of the onsite visit CQC confirmed the areas they would be focussing on the safe, effective, caring, and well-led key questions.

2. KEY FINDINGS

2.1. The CQC published the inspection report on 13 May 2021 and a copy of the full report is provided at Appendix A.

2.2. As CQC did not inspect all of the key lines of enquiry, they were unable to make any changes to ratings and all ratings remain unchanged from those issued in November 2019.

2.3. Although there were no changes in rating as a result of the inspection, the report demonstrates the hard work staff have put in to make improvements and it's extremely positive to note that CQC saw that '*During this inspection on the wards visited there was an improvement across all assessed domains.*

2.4. It is also positive to note that there were no 'must do' actions or breaches of regulation identified. There were seven actions CQC recommend we 'should do' to prevent the Trust from failing to comply with legal requirements in the future.

3. NEXT STEPS

3.1. As a result of the inspection, we are reviewing the full report and current position alongside the 2019 action plan to determine the status of the outstanding actions as it's likely some of these positive external assurances will support completion of a cohort of actions.

3.2. A status update will be provided at the next Quality and Safety Committee in June 2021 followed by the Board of Directors meeting in July 2021.

4. CQC ENGAGEMENT

4.1 We continue to have regular engagement meetings with the CQC via MS Teams and we recently met with CQC on 12 May 2021. At the 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.

5. RECOMMENDATIONS

The Board of Directors are asked to note the current position following the CQC inspection in March 2021.

Southport and Ormskirk Hospital NHS Trust

Southport & Formby District General Hospital

Inspection report

Town Lane
Kew
Southport
PR8 6PN
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www.southportandormskirk.nhs.uk

Date of inspection visit: 3 to 5 March 2021
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Southport & Formby District General Hospital

Inspected but not rated

Southport and Ormskirk NHS Trust provides healthcare to approximately 224,402 people across Southport, Formby and West Lancashire.

Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital.

The medical care service at Southport and Formby District General Hospital has 209 inpatient beds. The urgent care clinical business unit manages medical care services.

The medical care service operates from nine wards at Southport and Formby District General Hospital.

This consists of a cardiology ward (7a), a short stay unit (9a), a respiratory ward (14b), a stroke ward (15b with two hyper acute stroke beds), an emergency assessment unit (10a) and three care of older people wards (9b, 15a and 7b).

The trust had 18,293 medical admissions from November 2019 to October 2020. Emergency admissions accounted for 10,037 (54.9%), 168 (0.9%) were elective, and the remaining 8,088 (44.2%) were day cases.

For the reporting period (November 2019 to October 2020) admissions for the top three medical specialties across the trust were:

• General medicine: 12,144

• Clinical Haematology: 4,720

• Pain management: 637

We carried out this unannounced focused inspection following information of concern received from the public. We received information about patients absconding from wards and that patients and their families had not always been involved in decision making regarding the application of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). We inspected safety processes in the trust's medical care services. We also looked at the wider oversight and management of risk, governance and safety of patients across the service.

On the inspection we were limited to the wards we could visit due to the COVID-19 infection risk. We visited five out of the eight medical wards which included the medical emergency assessment unit (EAU), ward 11b the general medical /gastroenterology ward, ward 7a the cardiology including coronary care ward, 14b the respiratory ward and 9a the short stay ward.

We did not inspect all of the key lines of enquiry as our concerns were related to specific risks. We inspected against parts of the safe, effective, caring and well-led key questions.

Our findings

We previously inspected medicine at Southport and Ormskirk NHS Trust in August 2019 as part of our comprehensive methodology where we rated the medical care (including older peoples care) service as requires improvement in safe, effective, caring and responsive and inadequate in well led.

During this inspection on the wards visited there was an improvement across all assessed domains. All the staff we spoke with were friendly and helpful. They spoke positively about the culture and the support and visibility of leadership on the medical wards.

We spoke with 23 members of medical and nursing staff. We reviewed 23 patient records, where we looked at specific documentation including care plans, risk assessments, mental capacity assessments, DNACPR records, patient 'rounding' documentation and patient care charts. Patient 'rounding' is a process of regular nursing checks to ensure patient's fundamental care needs are being met.

We spoke with nine patients during the inspection. We observed patient care using the Short Observational Framework for Inspection method (SOFI 2). The SOFI 2 tool provides a framework to enhance the observations we already make at inspections about the wellbeing of people using the service and staff interaction with them. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service. We observed a handover/patient safety briefing, bed meetings, and a task force meeting with the local commissioners. We took into account nationally available performance data.

Following the inspection, we requested and reviewed information relating to the concerns raised and the evidence we had gathered following the observations we had made.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

See the medical section for what we found.

Medical care (including older people's care)

Inspected but not rated

At this inspection we found that:

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction. This was an improvement against the requirement notice from the last inspection.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement from the last inspection.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The leadership of the clinical business unit had been reviewed and expanded. Although the leadership team were relatively new to their posts, they demonstrated clearly defined and visible leadership roles and lines of accountability. This was significantly better than at the last inspection.
- The service managed patient safety incidents well. Managers investigated incidents, shared lessons learned with the whole team and the wider service and ensured that actions were implemented and monitored. There were some incidents relating to poor discharges which the trust was taking action to improve.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The dashboard showed moves for patients were being monitored and were not excessive.
- Whilst we did not inspect infection prevention and control processes as part of this inspection, we did not identify any concerns in relation to the environment and we saw that staff were following appropriate guidance in relation to social distancing and the use of personal protective equipment on the wards we visited. We highlighted a minor observation where we saw staff huddled together around the nurse workstation on Ward 9a as it was unclear if social distancing guidelines were being met.
- We spoke with senior leaders on the day of the inspection for the trust's action regarding one patient's potential significant weight loss and the discharge safety for two patients. The trust identified some immediate learning and training actions in response to the concerns raised, however the management of the patient's nutritional needs and the discharges were satisfactory.

However:

- Staff supported and mostly involved patients, families and carers to understand their condition and make decisions about their care and treatment. However, there were a small number of instances where the family had not been involved in meaningful conversation around the making of important decisions about resuscitation, however, a recent audit demonstrated improvement in this area.
- Staff completed but did not always update risk assessments for each patient. However, falls risk assessments had improved since the last inspection and staff identified and acted upon patients at risk of deterioration.
- The service did not always have enough substantive medical staff. Although, managers regularly reviewed and adjusted staffing levels utilising locum and bank staff and new roles had been introduced to help keep patients safe.

Medical care (including older people's care)

- At the previous inspection we found consultants did not lead daily ward rounds on all wards and consultants were not available on wards at weekends. At this inspection we found that this had improved. Consultant ward rounds varied, being held two or three times a week. In addition, multi disciplinary board rounds were held daily on weekdays. This included medical, nursing, allied health professionals, social worker and a discharge coordinator daily on weekdays. Over the weekends there was a discharge ward round on the ward carried out by a consultant and a junior doctor. We were told there was access to additional consultant reviews as required. Consultants were now present on site at weekends, with on-call consultants available during out of hours periods.
- Staff mostly kept detailed records of patients' care and treatment although there were separate records for nursing, medical and allied health professionals. The lack of an electronic patient record (EPR) system meant it was more difficult to holistically review the care of an individual; the trust had identified this risk which they were monitoring. A digital strategy had been implemented and the next planned programme of work being an Electronic Prescribing System.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' needs. Staff did not always fully and accurately complete patients' fluid charts where needed, although this had improved from the last inspection.
- Staff provided emotional support and understood patients' personal needs and had provided contact to families and carers whilst visiting had ceased due to the COVID-19 pandemic.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Staff completed and mostly updated risk assessments for each patient to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration. The risk of patients absconding had not always been assessed or acted upon. Falls risk assessments had improved since the last inspection.

Staff completed a patient risk assessment and care planning booklet for all patients on admission. We found initial assessments were completed for patients who used the service however, the reviews of these risks were not always fully completed.

We reviewed the records for 17 patients on wards 11b, 4b, 7a, 9a and emergency assessment unit. We found staff had not updated or reassessed these for two of the records. The guidance for staff stated, 'reassessment as part of ongoing care plan review'. However, we found additional care plans had been introduced for both of these patients where concerns were identified. This included management of patients with breathlessness, those who require deprivation of liberty safeguards (DoLS) assessments and required their vital signs monitoring.

Medical care (including older people's care)

At this inspection we saw that the service continued to use mainly paper based patient records, though observations using the National Early Warning Score (NEWS2) were recorded by nursing staff on an electronic system. NEWS2 is a patient safety tool which improves the detection and response to clinical deterioration in adult patients. Records we reviewed showed scores were correctly calculated and that patients were escalated for medical review following this.

Concerns had been raised regarding patients absconding from inpatient wards. We were told on the inspection that if a patient absconded, the missing person protocol was activated. Patient risks were assessed as part of routine DoLS assessment and would be documented in the patient's care plans.

We reviewed the 'Policy and Protocol for the Missing Patient CLIN CORP 76' provided by the trust. This states that; 'on admission to in-patient areas the patients should have an assessment for an 'Enhanced Level of Supervision' and if the patient is identified as being at risk of absconding the appropriate level of supervision must be provided and 'consideration must be given to the completion of a risk assessment for individual patients'.

The policy appropriately referred to the Mental Capacity Act (2005) and the use of restrictive practice; the Mental Health Act (1983) and clearly defines the procedure for a missing patient including escalation. Learning requirements are also noted for relevant designations of staff. Monitoring is after any incident and there are helpful checklists included in the procedure.

An initial assessment of Enhanced Level of Care (ELOC) assessment should be completed for all patients in inpatient areas. This was comprehensive and resulted in one of three levels of supervision. Within the list of reasons for enhanced level of care it referred to potential for absconding. The assessment was reviewed daily.

We reviewed three records for patients who had absconded and found that the ELOC assessment was only contained within the notes for one patient. The form was either not completed or was absent from the other two records. Therefore, the risk of absconding was only recorded for one of the three patients.

The trust had a behavioural observations chart and there was also a hospital passport document which could be initiated to identify support required for patients who had specific requirements related to behaviour.

The trust had introduced new assessments for falls and cognitive impairment which were embedded in the risk assessment booklet.

There was evidence that mental capacity assessments were being undertaken for patients, particularly for patients who had been subject to deprivation of liberty safeguards. Medical staff completed mental capacity assessments if a patient was identified as lacking capacity.

Capacity assessments were also undertaken during an in-patient stay if the patients' ability to consent had changed, for example post-operative delirium. We saw evidence in patient records that DoLS records were accurately completed and were recorded via the trust's incident reporting system. Staff told us that capacity assessments were discussed at consultant rounds and on ward board rounds.

The consultant was aware of one instance where a patient absconded from the ward. The trust safeguarding team were involved and the missing person's protocol was initiated. We were told of another incident where a patient was identified as a potential absconder. Records showed the patient was spoken with and a care plan was in place for de-escalation of risk through engagement and ongoing monitoring of this patient.

Medical staff we spoke with told us that mental health liaison support was available for psychiatric support, and the mental health liaison responded promptly when referrals were made.

The service had a pathway for patients with acute kidney injury (AKI). We saw training materials were provided on the wards with staff around the risks of acute kidney injury and how to accurately monitor patients to prevent such risks occurring.

We observed a nursing handover meeting on ward 7a and saw it contained all information required to keep patients safe.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

This was an improvement against the requirement notice from the last inspection. The inspection team reviewed the nursing staff vacancy rate across the five medical wards and found that although the level of band 5 vacancies ran at an average of 7.13 whole time equivalent (WTE) on each ward, the trust had recently recruited several band 5 nurses who were due to start work, as well as nurses from the International Nurse recruitment programme who were either due to start or were currently completing their induction training.

The vacancy rate did not have an impact on the safety of the services provided, with locum/agency staff and bank staff being utilised to fill shifts and the number of care hours per patient was above the national average during February 2021.

We also reviewed the level of sickness across the wards and found that the average rate of sickness absence across the five wards, in February 2021, was 6.3 WTE nursing and midwifery staff. This was above the trust sickness rate trajectory which was between 3.7-3.9 WTE per month.

The medical care service had introduced the role of staffing matron and each day one matron was assigned that role. This was a rotating role shared across the matrons. In addition, roster performance was monitored as part of the ward performance review meetings on a monthly basis.

The matron for staffing reviewed staffing levels across the wards for that day. Each ward manager completed a daily ward acuity tool, which highlighted the acuity level of patients on that ward and any additional staffing needs (such as for one to one care).

The matron for staffing carried out a walk round of all medical wards at 7:30am to review staffing, including any absences or requests for additional staff (for example, one to one due to increased acuity). This information was then added to a staffing spreadsheet at 8:00am and was then discussed at daily huddle with the urgent care clinical business unit (CBU) head of nursing and medical ward matrons. If any shortfalls were identified, then additional staff were requested, either through transferring staff from other medical wards with surplus staff or by using bank / agency staff.

Medical care (including older people's care)

We were advised of three spreadsheets used for managing staffing all of which were live documents that were updated daily. There was a staffing acuity tool (safe care acuity tool) in which the patient acuity scoring was measured against the safer nursing care evidence-based tool, reportable through “Safecare”, which supported the safe staffing decisions made within the staffing huddles combined with bed occupancy. The patient acuity tool showed the acuity level of patients on that ward using a scale (level 1 to level 3).

There was also a staffing spreadsheet which was a live document that listed actual staffing verses establishment on each ward and was updated daily. The spreadsheet used a RAG rated system; red if below safe staffing standards, amber if staffing below establishment and green if there was sufficient staffing.

The third document was a COVID-19 update spreadsheet, a separate online document that was updated daily and showed how many patients were on a ward and how many times they have been moved.

The medical care senior leadership team informed us that, as part of pandemic and wave preparedness, they had developed a live oxygen dashboard which clearly identified the number of patients with oxygen dependency per ward, this was also used as an additional indicator of acuity.

Allied Health Professional teams attended and reported into the daily staffing huddles during the pandemic and the trust reported local multidisciplinary staffing outcomes to all senior and on call teams three times a day. We were advised that when there was exceptional demand on the wards a medical liaison officer at consultant grade supported the command and control arrangements for the site and was responsible for supporting wards with high acuity.

During the inspection we noted that across the wards there were not always the planned number of trained nurses on duty, however, staff informed us that the staffing level was safe due to the lower occupancy and acuity levels on the ward at those times.

Staff on ward 14b mentioned that on occasions, due to the acuity level of patients and the need to provide one to one care to some patients for example, patients on non-invasive ventilators, this affected the staffing level on the ward. In such cases they could escalate their concerns to the staffing matron and/or bed managers.

Additional cover was often filled by substantive staff covering vacant shifts, bank or agency staff or staff being moved from other areas of the hospital.

Our team of inspectors spoke to patients, across the medical wards, who told us that although they felt there were enough staff, they generally felt that they could do with more, as the staff were always extremely busy.

Some patients felt that due to the staff workload they did not always have time to interact and talk to patients. They did however feel safe because there were always staff around.

On speaking with nursing staff across the wards we were advised that there were days where it was particularly busy and additional staff would be of benefit, however, at no times did the staff feel that there were not enough staff to provide safe care.

The senior leadership team advised us that they have an evolving recruitment strategy for the nursing workforce in place, with a significant amount of proactive work ongoing, including strengthening their engagement with external partners, including local Higher Education Institutions, Health Education England, other local Trusts and NHS Professionals. They also had a positive international nurse recruitment process in place.

Medical care (including older people's care)

Some of the medical care wards had already had some international nurses join their teams, however, until these nurses had successfully completed their six to eight weeks induction training and had been signed off as competent, they remained supernumerary to the staffing count. The trust reported they now had 45 international nurses on-boarded with a further 50 international nurses in the pipeline to date, with interviews still ongoing.

To assist with the facilitation of the induction training for overseas nurses the trust had identified a training lead. The senior management team advised that the induction programme had had excellent feedback.

The trust had also utilised the skills of 82 final year nursing students since September 2020. They had enhanced student placements and experience and were working with several other trusts on a pan-Cheshire and Merseyside placement expansion programme using Health Education England funding. It was hoped that this would increase the number of students and strengthen the recruitment into newly qualified nursing posts.

Additionally, the trust had launched three new apprentice training options from September 2020, Trainee Nursing Associate, Nursing BSc Apprentice and Nursing MSc Apprenticeship to help improve recruitment of nursing staff going forward.

They had been working with educational providers to improve the healthcare assistant supply by reintroducing the ACORN programme, recommencing the Care Support Worker Development programme with NHS Providers and had scoped engagement opportunities with the NHS Cadet scheme.

To maintain continuity of care the trust advised that they had encouraged agency staff migration to bank and continued focus on the block booking of flexible workers.

As the trust had stood down all non-essential activity, to support safe staffing across the trust, this allowed re-deployment of clinical staff groups to support medical wards and critical care units.

We were advised that seven-day administration services had been commenced during the last wave of COVID-19. This had continued and provided further support to clinical areas alongside the deployment of staff groups.

To ensure there was enough senior nurse cover across the wards the clinical business unit had reviewed their use/spend on locums and the number of nursing vacancies and this had allowed them to uplift some of their band 5 nurses to band 6. Additionally, some of the agency nurses had accepted permanent band 6 positions with the trust.

Medical Staffing

The service did not always have enough substantive medical staff. However, managers regularly reviewed and adjusted staffing levels utilising locum and bank and new roles had been introduced to help keep patients safe. We were told patients received medical reviews from consultants and consultants were available out of hours and at weekends.

The leadership team shared with us that the service has had challenges with medical staffing, historically as well as through the pandemic. They had undertaken an urgent medical staffing establishment review to see what staffing was needed to meet the needs of the service and had agreed a plan to include a skill mix of existing vacancies and new posts to include advanced clinical practitioners and physician's associates. The trust had recently developed a tool to assess all staffing needs, based on bed numbers. It looked at real time availability and minimum staffing required versus availability. It was a high priority for the trust to get a sustainable workforce.

Medical care (including older people's care)

The trust had plans in place to increase their recruitment of consultants. The Trust was reviewing opportunities with other Trusts to mitigate vacancies, for example in Cardiology.

They had approached a local University and were looking at a formal partnership with the University. There was currently an advert out for a joint academic/clinical specialist position. They told us they knew where they needed to get to and were working towards that.

At the time of the inspection there were two consultants on maternity leave. Three whole time equivalent consultant posts had been created in November 2020 through a review of skill mix. These posts were in cardiology, gastroenterology and diabetes/endocrine. We were told all three posts were currently being advertised.

Following our inspection, the service provided information that showed in February 2021 the service had 14.55 whole time equivalent (WTE) consultant vacancies within medicine. However, the service employed locum and/or bank doctors to cover the vacancies on the general medical rotas. The trust had many locums who were on long term contracts as they wanted to continue working at the trust.

The current vacancy at consultant level was partially mitigated by the employment of long-term NHS locum and agency locum staff, equivalent to 11 WTE. Despite the filled posts the service continued to run at a deficit, with a gap of 4.68 WTE against funded posts.

Staff we spoke with told us the induction for locum medical staff gave them enough information to be able to work on the wards. A locum middle grade doctor told us they felt medical staffing had improved, particularly as there were additional locum doctors to support medical staffing levels.

Due to the COVID-19 pandemic the service had introduced an additional consultant on site (from 5pm to 9.30pm), who provided cover across the medical wards. On ward 11b we spoke with a specialist consultant who had responsibility that week to oversee all gastroenterology patient referrals from other wards and departments. This was designed to streamline consultant review for patients that required gastroenterology care and treatment. We were told that during out of hours, there was one consultant on-call, no second on-call consultant, and the on-call rota was across all medical wards.

We saw that on ward 7a there were two consultants on site from 9am to 5pm weekdays, again with cover provided by the general medical on-call rota during out of hours and weekends.

The service had three consultant gastroenterologists, one consultant vacancy had been advertised, and the service used a locum consultant as additional cover. Funding had been sought for a fifth consultant post and there was a plan to advertise for this once approved. We were told there should be six consultant posts, in order to fulfil 7-day working rota requirements. At the time of the inspection, the on-call consultant was included in the general medical rota, so the on-call consultant may be a general physician but not a gastroenterology specialist. The consultant stated there were no gaps in the middle grade and junior doctor rotas.

We were told that during the COVID-19 pandemic there had been instances where gastroenterology patients were placed across other medical wards. The medical staff had a list of these patients so were able to review these patients in other wards. Over the last few weeks, the impact of Covid-19 had reduced and all gastroenterology patients were now located on ward 11b. This improved staff being able to manage these patients more effectively.

Medical care (including older people's care)

On ward 14b there were two consultant teams. Ward rounds were carried out three times a week, with a board round each day. The consultant on call was present until 7pm and then on call until 9am. During COVID-19 there were two consultants present during the day plus a third from 5pm9pm who saw the new acute patients. This meant all acute admissions received a senior review in a timely way. We were told this level of consultant cover would be stepped down as business as usual started to resume.

There was a designated manager and an operational manager responsible for the management of the medical rota. Both were supported by a rota co-ordinator for the planning and securing of additional medical staff. Daily updates were held to look for any emerging staffing issues for the day and for any upcoming gaps on the on-call rota. A weekly rota was generated and ward staffing for all medical wards was reviewed to ensure safe cover, reallocating locum and bank doctors where required. We reviewed a rota for March 2021 which confirmed this. In addition, a weekly staffing review meeting was held to discuss staffing in more detail and for any emerging risks that required escalation.

The service was using alternative specialist roles to support the medical staffing team including specialist nurse practitioners and physician associates, specialty trainees and specialty doctors. The senior leadership team told us that with the introduction of physician associates within medicine the service had 10 additional doctors in post.

Information from the risk register showed that all vacant posts were being advertised, shortlisted, and recruited in a timely manner. Vacant posts were clinically assessed to determine whether locum/bank was needed. There was evidence in the risk register that the trust was working with partners to mitigate risks to services.

At the previous inspection we found consultants did not lead daily ward rounds on all wards and consultants were not available on wards at weekends. At this inspection we found consultant ward rounds varied being held two or three times a week. In addition, multi-disciplinary board rounds were held daily on week days. This included medical, nursing, allied health professionals, social worker and discharge coordinator daily on weekdays. Over the weekends there was a discharge ward round on the ward carried out by a consultant and a junior doctor. We were told there was access to additional consultant reviews as required. Consultants were now present on site at weekends, with on-call consultants available during out of hours periods.

Patient records

Staff mostly kept detailed records of patients' care and treatment although there were separate records for nursing and medical and allied health professionals. Records were clear, mostly up-to-date and stored securely. The lack of an electronic patient record (EPR) system meant it was more difficult to holistically review the care of an individual however, the trust had identified this risk. A digital strategy had been implemented with the next planned programme of work being an electronic prescribing system.

At the last inspection we saw patient records were fragmented with doctor and nursing records kept in different files and drawers. At this inspection we saw that this remained the case and that the service continued to use mainly paper based patient records, however, the medical handovers and NEWS2 assessments used an electronic system.

During this inspection, we viewed 17 patient care records. We saw they were legible and clear however; we saw some occasional omissions of signatures on records. For one patient we found that the trust checklist documentation had not been used for a discharge. We saw that there were a lot of different patient records, which must cause some duplication of work. The allied health professionals and the medical staff wrote in the medical notes, but the nurses had their own separate notes.

Medical care (including older people's care)

On ward 11b, we escalated concerns for one patient with deteriorating weight and two sets of patient records where we could not locate the discharge paperwork. We asked for records which could confirm what actions the trust had taken regarding the issues of concern identified with the above patients. The trust identified some immediate learning and training actions in response to the concerns we raised. Whilst the trust acknowledged their own process was not consistently followed, we were given assurance that the patients were discharged safely.

We identified there were some inconsistencies in the discharge checklists. A review of one patient record highlighted that the checklist was completed but did not have a second signature in line with the policy. This was being addressed in the form of supportive education with the individual. The trust confirmed that whilst their own process was not followed, the patient was discharged safely. For another patient we found that the trust checklist documentation had not been used. However, there were no concerns identified relating to the safety of this discharge. Management confirmed that a trial discharge form was in place however we found this not consistently used on the wards we inspected.

During this inspection there were no patients with mental health problems on the acute wards we visited, however we reviewed the records for two patients with Deprivation of Liberty safeguards in place and no issues were found.

On the risk register we saw that the dementia and delirium assessment for find, assess, investigate, refer process (FAIR assessment) was being carried out on paper, whilst the new electronic module was being developed.

Matrons audited compliance with nursing documentation standards every month as part of the matrons' checklist. The results for ward 11b and 14b showed improvement in compliance over the last six months with compliance in January 2021 exceeding the target of 95%.

The senior management team told us that there was a focus on improvement, the quality improvement board were looking at doing a refresh of the end of bed leaflet around fundamental care. This was piloted at the time of the inspection. The trust had plans in place to commence an electronic patient records system by 2022. Funding for this had been received in early 2020 but the move was delayed due to COVID-19.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions were implemented and monitored. There had been an increase in incidents related to discharges, however, the trust had in part contributed to this by creating a mailbox where issues around patient discharge could be reported by external partners, with the aim of learning and improving.

All the staff we spoke with knew what incidents to report and how to report them. Staff reported incidents through an online reporting system and staff we spoke with could give examples of the types of incidents they had reported.

Managers told us there was a culture of high incident reporting and staff we spoke with confirmed they were encouraged to report incidents by their managers. Trust level NRLS data supported that there was a good reporting culture.

From our review of national reporting and learning system (NRLS) information, we found the medical department had 920 incidents reported between September 2020 and February 2021. There had been no never events reported (a medical mistake that should never happen) related to medical care services during this period.

Medical care (including older people's care)

The hospital had an incident reporting policy in place. Staff had a responsibility to report incidents on the hospital's incident reporting system. The highest incidents reported were patient incidents, mainly slips, trips and falls (306). The next to top group was access, admission, transfer, discharge (125). There were 20 discharge planning failures, 14 discharge delay or failure and 10 inappropriate discharges, nine transfer delay / failure / inappropriate, five discharge self against medical advice. Eighty percent of these were reported as no harm, 15% as low harm and there was one death. In comparison during the same period, 13 discharge failures were reported in surgical specialties, of which most related to take home medication issues.

One of the concerns raised prior to this inspection was that patients were discharged at inappropriate times without the right care and support in place. Staff told us all patient discharges after 5pm were required to be reviewed by a matron on the medical wards as an additional monitoring step to check all discharge checklists were completed and appropriate discharge plans were in place. There was no formal cut-off time for when patient discharges stop but, in most cases, patients were not discharged after 7pm.

We spoke with a consultant who told us that board rounds had been in place for approximately three years and helped to facilitate the discharge process. Some delayed patient discharges were unavoidable due to factors outside of hospital control, for example, waiting for the availability of community beds. On ward 11b staff told us they were not aware of any inappropriate or unsafe discharges.

A further concern raised with the CQC prior to the inspection was that patients were moved from ward to ward and it was not uncommon for a patient to experience up to 10 moves in one hospital stay. Bed moves for individual patients were monitored via the Trust dashboard and minimised wherever possible. A consultant told us that the number of moves for patients overall had improved and settled down over the last few weeks. However, this may not be to optimum levels because patients had required moving wards due to the impact of COVID-19. With the recruitment of additional consultants, there was an aspirational plan to conduct gastroenterology in-reach service, so patients in the emergency department could be reviewed promptly and therefore reduce the number of moves.

Discharge facilitators liaised with the ward and the discharge team. Daily multidisciplinary meetings were held to look at those patients that were medically fit for discharge.

We attended the task force meeting which discussed discharges. This was attended by the ward nurse, discharge facilitators, social services and the patient flow team lead. The task force (in their current format) started a month before the inspection and was being trialed on two wards.

Any fast track patients were identified and complex discharges were discussed with actions to facilitate their discharge once medically fit. The team were knowledgeable about discharge options and placements. The discharge facilitators did a lot of the following up to free up nursing time and to maintain patient flow. There were six discharge facilitators in the team, there was recruitment ongoing for a seventh.

On the day prior to the inspection the discharge team (task force) facilitated 10 discharges. The team told us they did not feel that they would have been able to do this previously without this coordinated approach and joint working.

We attended the high impact action meeting which looked at the impact the discharge team had had. We spoke about a patient incident which was discussed as part of the rationale for inspecting. The matron very much felt it was an isolated incident; we were told that the ward discharges 85-90 patients per month and this issue had not been reported

previously. The team had spoken openly about it and actions have been put in place. A two-person discharge checklist had been put in place to ensure everything was checked prior to a patient leaving the ward, this included a 'stop before you go' visual check. During this inspection we did not see any evidence of this in practice, no posters or information for staff and no staff member referenced it when we spoke with them.

There was a system in place for patient safety alerts to be cascaded and responded to at a central hospital-wide team. The matrons and ward managers in each area were made aware of any alerts or actions required. Departmental managers reviewed all incidents, started investigations, put in place necessary corrective actions, reported externally and escalated any risks as required. The incident reporting system emailed all serious incidents to senior staff (matrons, head of governance) so if an incident was raised it would be actioned immediately.

Learning from incidents was shared in a number of ways. Incidents were discussed at daily safety huddles where any high-risk patients would be identified. Serious incidents were shared with staff through lesson of the week, which required a signature from staff to state they had read this. There was evidence that changes had been made as a result of feedback from incidents. We saw one ward had looked at themes following a number of falls on the ward. They had identified they all happened in one area and had made changes to that area to make it safer for patients.

Lessons from incidents were also shared at the weekly Harm-Free Care Meetings. These included involvement from the Deputy Director of Risk and Governance, the Director of Nursing and risk team. Meetings were recorded and minutes were shared with staff. We saw an example of learning from a patient concern we raised during this inspection. An incorrect height recording had been made on a patient's mid-upper arm circumference (MUAC) recording which had a negative impact on the next MUAC assessment. The ward was now working with the dieticians to ensure supportive learning around MUAC recording. In addition, the ward had purchased some weighing patient transport slides which were being rolled out, which meant going forward the MUAC would only be used in very exceptional circumstances.

There had also been learning from previous incidents relating to discharge concerns. For example; patients may not have appropriate clothing at the time of discharge. There was a plan to purchase clothing (fleece jackets, jumpers) so patients that did not have their own clothing could be provided with clothing if needed on discharge.

Also, a diabetic patient was discharged to a care home, but the home did not have the required blood sugar monitoring machine. Learning was taken from this and it was agreed that the required blood sugar testing machine would be provided by the hospital on discharge, where required, going forward.

We saw patient safety boards displayed on the wards. On ward 14b it showed it had been five days since the last patient fall and seven days since the last pressure ulcer. Themes of incidents identified on this board were, falls, pressure ulcers and discharges. Pressure ulcers and discharges were identified as a key area of focus.

Is the service effective?

Inspected but not rated

Nutrition and hydration

Medical care (including older people's care)

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' needs. However, whilst staff mostly completed fluid balance records accurately and completely, and the Trust had monitoring arrangements in place to check this, during our visit we noted three charts that were not fully complete. This had improved from the last inspection.

During the inspection we observed patients over the lunch and afternoon tea periods and noted that staff spent time with patients to discuss their lunch preferences on most occasions. On one occasion a patient's comments that they had had the same lunch three days in a row had been ignored by the staff member.

We noted that where patients were unable to feed themselves staff provided assistance with eating and drinking.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs, however we spoke to seven patients in the medical wards several of whom indicated that it was often difficult to get additional drinks outside of the scheduled tea times and that it would be nice to have access to more cups of tea.

Staff informed us that they had missed the dining companions for patients during COVID-19 as often patients did not eat because they lacked stimulation and having a dining companion to sit and chat with them often motivated them to eat their meals. They have, however, trained corporate staff who will come and sit with patients during mealtimes.

Senior leaders advised us that they had recruited catering assistants to some of the medical wards. They would hand out meals and drinks to patients, fill up water jugs and make sure that patients' hands were clean prior to eating. This had proved to be effective as patients were supported and it freed up clinical staff and healthcare assistants to undertake other patient care activities.

The senior management team told us that they had undertaken a quality improvement project for six months, delivered by staff from the critical care unit and critical care outreach team, to look specifically at nutrition and hydration and fluid balance recording. This piece of work commenced in August 2020 and included the development of a fluid balance standard operating procedure, a urinalysis standard operating procedure, a ward fluid balance audit (using a software package) and development of training materials and learning aids to assist staff in the recording and assessment of fluid balance. They were due to introduce the use of a web based application, but this had been delayed due to COVID-19.

We noted from the urgent care risk register that a new e- learning module relating to nutrition was available to all staff. This was essentially introduced as part of a project; however all staff were currently able to access and complete the learning.

We also noted that eight staff had completed the Mouth Care Matters Train the Trainer programme. Staff did not always fully and accurately complete patients' fluid charts where needed. Our inspectors reviewed the records of 22 patients across the four medical wards and found that on three occasions fluid balance charts had not been completed accurately or fully. We were advised that the trust undertakes audits of nutrition and hydration across the medical wards where they randomly reviewed 10 patient records to assess against 11 key criteria.

• Is the date completed?

• Does fluid balance chart contain correct demographics?

• Is the weight documented?

Medical care (including older people's care)

• Is measurable input recorded?

• Is measurable output recorded?

• Are sub totals calculated and correct?

• Is the total calculated?

• Is the total correct?

• Are all signature sections complete?

• Is catheter emptied at the end of every shift?

• Should the patient be on a fluid balance chart?

On reviewing the trust's audit results from June 2020 to February 2021, the Perfect Ward Score for fluid balance recording was between 75% and 95% (across all the medical units).

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. It was noted on reviewing patient records that the trust utilised the Malnutrition Universal Screening Tool (MUST) to identify adults who are malnourished or at risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it, however, prior to the inspection our inspection team had undertaken a review of incidents relating to nutrition and hydration on the medical wards and found that there had been two incidents where patients were not referred to the dietetic service despite this being required. The senior leadership team advised that actions have been taken to prevent recurrence of this and that the dieticians now have an electronic referral system in place.

They had also invested in aids to assist with eating and drinking, such as bright yellow plates for patients with dementia and two handled mugs to help with drinking.

Nutrition dashboards had been revised and matrons / ward managers provided access to staff while the roll-out of the project got underway.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement from the last inspection.

Medical care (including older people's care)

Prior to the inspection we had received concerns regarding the provision of communication with families whilst visiting was not allowed. During the inspection, however, we spoke with the senior leadership team who told us they had listened to patient feedback around improving patient care during the COVID-19 pandemic and had introduced teleconferencing calls to provide daily updates to family/next of kin. We were told that during the height of the pandemic the medical care wards had set up daily calls with families to keep them up to date with the patient's progress, however, as the acuity of the patients had reduced, patients who were able to make contact with their families themselves were encouraged to do so.

On speaking with the matron, she told us that she had spoken with every patient on the ward the day prior the inspection.

During the inspection we saw that staff interacted with patients in a respectful and considerate way and ensured that their dignity and privacy was maintained. Members of staff were observed spending time with a patient to discuss their forthcoming discharge, conversing positively with a patient whilst undertaking routine observations, assisting a patient to eat and drink, escorting a patient on a walk around the ward and assisting a patient who required the use of the bathroom.

As part of the inspection, we carried out observations using the Short Observational Framework for Inspection (SOFI) method during our inspections on wards 7a, 9a, 11b and14b. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the patients, the type of activity or non-activity they were engaged with and the style and number of staff interactions with patients. In each time frame there may be more than one type of engagement and multiple interactions with staff. Staff interactions are categorised as positive, neutral or poor. Some examples of positive interactions would include displaying respect, warmth and providing enablement for patients. Negative interactions may include withholding behaviour, such as refusing to give asked for attention, or not meeting an evident need; or failing to acknowledge the reality of a patient.

The observations were noted in five-minute intervals over a period of half an hour. We observed a total of 18 patients across the four wards.

Four, 30-minute observation periods were undertaken, one on each ward.

The general mood state for the group of patients throughout the observations was on average neutral for 68.5% of the period, positive for 21.75% and negative for 11.5%.

There was staff interaction with patients on an average of 39.5% of the time frames. These interactions with staff were noted to be positive on average 65.5% of the time and neutral for 26% of the interactions, however on ward 14b we observed that 29% of those interactions recorded were negative.

Staff interacted with individual patients between zero and nine times over the 30-minute timeframes. One patient was asleep throughout the observation and was left undisturbed. Where the observations occurred over a mealtime staff interacted with every patient being observed. Patients said staff treated them well and with kindness, with some patients advising that the staff were well-mannered, efficient and cheery, despite being very busy.

One of the concerns raised was that patients were moved from ward to ward and being left on corridors. We did not find evidence of any inappropriate patient moves around the hospital during the inspection.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers whilst visiting had ceased due to COVID-19. They understood patients' personal needs.

During conversations with staff we noted that they understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and had made sure that plans were in place to provide emotional support.

From November 2020, volunteers from the local hospice, supported with patient communications (Video-conferencing calls and the hospital passports). Between November 2020 and the end of February 2021 the team had facilitated approximately 645 video-conferencing calls for patients and their families.

We found on inspection that there was some communication with families, and this was recorded and monitored but in a variety of ways. On Ward 9a, we noted that a communication sheet was used to record when conversations had taken place with family members. On other wards we observed in patient records that a record of communication with their family had been noted in the patient's nursing record.

During discussions with staff on ward 9a, we were advised that the band 7 nurses reviewed each patient's record daily to check if family have been in touch, or if an update was needed for the family. Other wards used different methods of checking that communications had taken place.

We were advised by the senior leadership team that although video-conferencing calls were arranged for patients to keep in touch with families, it had been noted that a higher number of elderly patients were unable to manage these calls using video technology, so staff had reverted to using a telephone to keep them in touch. Additional telephones had been ordered for the medical wards to increase the capacity for patient calls.

Staff supported and mostly involved patients, families and carers to understand their condition and make decisions about their care and treatment. There were a small number of instances where the family had not been involved in the making of important decisions about resuscitation, however, a recent audit demonstrated improvement in this area.

Prior to the inspection, concern had been raised that the involvement of the patient and family in the decision-making process for Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) had not happened. Therefore, on inspection we reviewed three patient records where this decision was in place and found them to be completed appropriately and noted that conversations were documented as having taken place with patients and/or their family regarding their decision as to whether they should be resuscitated in the event of a cardiac arrest.

We also reviewed incidents reported regarding DNACPR between 1 January 2020 and 16 March 2021, we found only one reported incident within the medical services. However, shortly after the inspection we had a further two instances raised with us regarding the lack of involvement of the patient and family in these decisions. These were raised with the trust as a concern and they were being investigated.

We reviewed additional information from the trust including their DNACPR policy, improvement plan and an audit which demonstrated improved compliance in most areas since changes had been made.

Medical care (including older people's care)

Is the service responsive?

Inspected but not rated

Managing and Learning from Complaints

The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff. The service included patients in the investigation of their complaint. Response times had been slightly longer than the trust target but had improved since the last inspection.

The service received 39 complaints between 01 September 2020 and 28 February 2021. The highest number (8) were for ward 11b but there was a spread across all the wards within the medical service ranging from two to five.

The trust had a target of 40 days turnaround for complaints. In the August 2020 integrated performance report to Board, complaints average timescale for closure remained under the target with the month's average at 35.1 days. Thirteen complaints had been received at the trust in month with four in general medicine, one in cardiology, and one related to rehabilitation. In the December 2020 integrated performance report the complaints average turnaround had significantly improved to 42.5 days following issues caused by staff absence in November 2020 when the average was 67 days. A weekly complaints clinic had been established and had contributed to the improvements in this area. The January 2021 the integrated performance report stated average turnaround time of 49 days. The February 2021 position was much improved with a reported average turnaround time of 24 days.

The trust identified an important need to introduce a trust wide Patient Liaison and Advise Service (PALS) and this was implemented in September 2020. Since implementation there had been over 2000 contacts with patients across the trust, to achieve resolution. Only three of these had resulted in a formal complaint. The number of concerns managed through the trusts PALS service between September 2020 and February 2021 was 140.

During an interview with the local leaders we were informed that all complaints were reviewed by the Head of Nursing and that they were conducting a thematic review of complaints and incidents in order to learn from them. The new leadership team had prioritised both prompt response and investigation of outstanding incidents/complaints against trust timescales, and were focused on learning from themes as part of quality improvement.

Patient information leaflets were available, we were provided with copies of patient information leaflets relating to dementia and delirium, which were available to patients and family/representatives to provide them with further information relating to the diagnosed condition.

We were advised that the medical wards used a "Hospital Passport" for patients living with dementia. This ensured that important information relating to the patient was available in one place. The document was completed together with the patient and their family/representative. Information including what the patient preferred to be called, what they liked to eat and drink and important details relating to issues such as advanced care plans and medications were recorded.

Medical care (including older people's care)

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The leadership of the clinical business unit had been reviewed and expanded. Although the leadership team were relatively new to their posts, they demonstrated clearly defined and visible leadership roles and lines of accountability. This was significantly better than at the last inspection.

We saw on the inspection that there were matrons responsible for the wards we visited. There were three matrons in post with a fourth starting in April 2021. The matrons were visible and visited the wards regularly and escalated any concerns. There was a matron present every day, including weekends, up to 8.30pm. Matrons had an open-door policy to support staff if needed. There were regular engagement forums held by the senior management team in order that staff were able to raise concerns.

There had been a nursing structure review which had added a lead nurse to provide oversight of matrons and gave the matrons capacity to work at ward level whereas before that had not been possible. It was also noted that there had been significant changes at ward leadership level, there were new band 7's in post who are enthusiastic. There had also been an increase in band 6 nurses to enable a member of senior staff to be on every shift.

On site we had an interview with the directorate manager and Head of Nursing. They told us that senior leaders had identified leadership in the medical service as a concern and in response had redefined the directorates and had improved the governance structures. These changes included a review of how the leaders were performing and how visible they were. They felt this had enabled them to understand, act on and monitor the improvements required across the directorate. There had been conversations with staff regarding a shift from monitoring performance to reporting on quality and care. They felt that staff had stepped up and were focusing more on quality now. They had received the financial support they required to support the improvements.

The new structure had removed some of the hierarchy and had been very well received by staff as it was starting to address concerns with management and was reassuring clinicians who had previously expressed that they were not happy. The local leaders spoke about implementing a lot of changes, some in response to COVID-19 and others to local concerns. To monitor the improvements, they were repeating staff surveys and had noted that people who were disengaged with senior management in the past are now engaging.

They had facilitated an away day with ward managers and discussed the challenge in the recruitment of band 5 nurses which was a national challenge. It was agreed to extend band 6 roles with individual professional development plans to develop staff with clear conversations about roles and the development of leadership roles.

Culture

Medical care (including older people's care)

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

During the inspection we saw teams working together, we spoke with members of staff who told us things were improving and that the new executive team in place had made significant improvements and there was more engagement. They told us that the wards were well run and focused on patient care with good learning and support.

One consultant told us that changes made by the executive team were starting to filter down to wards and that there was more structure to medical meetings and there was more involvement from senior leaders (associate medical director and the medical director) in these meetings. Directorate managers were also more involved and there was an improved level of engagement.

They also told us there was impressive support and processes available for medical staff during the COVID-19 pandemic, such as provision of PPE and resolving issues with PPE availability. The trust had made a decision to test staff at an early stage, which helped quickly identify staff that needed isolation, swab testing was also expanded to medical staff family members and this helped optimise the number of self-isolation days taken by staff and helped them get back to work.

Staff told us there were good working relationship between medical and nursing staff and strong team working, everyone was very motivated and there was a feeling that the teams have really moved forward. They also told us that leaders were friendly and approachable. Staff felt that issues from the past had had a line drawn under them and people have moved on.

There was a freedom to speak up / whistle blower policy and a freedom to speak up (FTSU) team was in place across the hospital. The hospital chaplain was the FTSU lead. Staff could access the FTSU team if needed and information was available on the intranet site for staff. The matron we spoke with was not aware of any significant ongoing FTSU concerns.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The clinical risk registers were electronic, there was a departmental (Ward) and urgent care clinical business unit risk register, local risk registers are managed by the ward managers / matrons and there is a weekly risk management and governance meeting where risks are reviewed.

We reviewed the risk register for the urgent care clinical business unit and found that it identified relevant risks, there were six risks that had been identified as extreme: these included requirement to improve older peoples' care; risk due to nurse staff vacancies across the clinical business unit; risk due to the number of consultant vacancies in medicine; risk to business continuity; risk to patient flow and capacity on the Southport site and risk to the provision of coronary care including telemetry. All risks had initial and current risk ratings, all had been reviewed and had a risk lead allocated. All extreme risks had been reduced by mitigating actions taken which were articulated in the register. There was also a target risk level identified.

Medical care (including older people's care)

In response to the risk around the need for improvements in older peoples care the trust reported that there was an 'Older People's Training Programme' in place monthly with a focus on changing culture, ethos, behaviours and increasing awareness of risk and 'basic' care needs in a vulnerable and frail population. There had been an initiative introduced called 'End PJ paralysis Get Up, Get Dressed, Keep Moving'.

A Dementia and Delirium team had been recruited and were providing training, education and advice for staff in relation to concerns for patients, carers/family and staff. The falls risk assessment and care plan are now embedded.

As part of the perfect ward initiative, matrons carried out monthly audits to review records, observe care and speak with patients. The perfect ward audits covered areas including nutrition and hydration, VTE(venous thromboembolism) risk assessments and discharge planning.

Assurances on quality and performance from matrons came via monthly performance reviews and local quality ward audits. Ward 14b had achieved silver status. There was a matron's audit and harm prevention app which gave live reports on Perfect Ward data. There was also a monthly performance review with the head of nursing.

Each Friday was 'quality day' where there was a meeting with the director of nursing, assistant director of nursing, head of nursing and matrons; they had an area of focus and visited clinical areas. This was a clinical day for matrons.

There was a harms prevention meeting every week where the ward managers presented information. They looked at initial incident reviews, root cause analyses or any other incidents of concern.

There was also a serious incident meeting every week and weekly patient safety meetings across the clinical business units.

Engagement

Leaders and staff actively and openly engaged with patients.

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should be given the opportunity to provide feedback on their experience. The investigation team reviewed the FFT data received for wards 9a,11b and 14b.

Patients gave positive feedback about the service. Across the wards, between 1 September 2020 and 28 February 2021, an average of 61% of those who responded rated the service as very good and an average of 22.3% rated the wards as good.

An average of 84% of patients stated that they would recommend the service to friends and family, whereas an average of 10% would not recommend the service.

Outstanding practice

We found the following outstanding practice:

Medical care (including older people's care)

The medical care service had undertaken a quality improvement project in partnership with the local hospice to look at how fundamental care could be improved, based on the ethos of individualised patient centred care as experienced on the Oasis Ward, during wave one of COVID19. The remit of the team was to support staff and develop skills in relation to the delivery of the fundamentals of care and help develop holistic patient centred care as experienced on the Oasis ward. The Oasis Team was also supporting the review and launch of the Care certificate.

Areas for improvement

SHOULDS

• The trust should continue to improve the review of patient risk assessments.

• The trust should continue to improve the involvement of patients and their families in decisions regarding care and treatment where DNACPR is considered.

• The trust should continue towards electronic patient records to promote accuracy of holistic record keeping.

• The trust should continue to improve discharge arrangements to ensure safe patient discharge.

• The trust should continue to act to address the high number of registered and unregistered nursing vacancies.

• The trust should continue to improve the assessment of the nutrition and hydration needs of patients including the accurate completion of fluid and nutrition charts.

• The trust should continue to address the number of medical staffing vacancies across the medical care service.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a lead inspector and two other CQC inspectors. In addition, the team was supported by a specialist advisor. Specialist advisors are experts in their field who we do not directly employ. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB093/21**	**FOI Exempt**	**NO**
Report Title	**COMPLAINTS ANNUAL REPORT - 2020/2021**		
Executive Lead	Bridget Lees, Executive Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant Director of Integrated Governance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides an overview on Complaints / Concerns received by the Trust in 2020/2021

Executive Summary

In summary the report highlights that:

- There was a 16.8% reduction in the numbers of complaints received from 2019/20 which may in part be as a result of the Covid-19 and reduced attendances.
- The PALS Service, which was introduced in September 2020, has proved to be an asset to the Trust as it has been well received by patients, families, and staff. This is evidenced by the steady increase in contacts with the team showing early resolutions and a reduction in complaints.
- The Trust was inspected by CQC in March 2021 where CQC reviewed complaints in the Urgent Care Business Unit and noted '*The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.*'
- The introduction of governance learning bulletins which includes learning from complaints, has proved positive as these are shared amongst all staff from ward level to share learning.
- The Integrated Governance Team are working with CBUs to improve overdue actions as there is recognition that there has been additional pressure within Urgent Care particularly, which is in part due to the pandemic as well as vacancies for matrons and a patient safety manager which have since been recruited to.
- Compliance around the 40 day response times has shown improvements but fluctuated and efforts in 2021/22 will focussed on consistently achieving this timescale.

Recommendations

The Board is asked to receive the Annual Complaints and Service Experience Report for 2020/21.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ☐ **SO3** Efficiently and productively provide care within agreed financial limits
- ☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby, and West Lancashire	
Prepared By:	**Presented By:**
Mandy Power	Bridget Lees

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Centre

NHS
Southport and Ormskirk Hospital
NHS Trust

ANNUAL COMPLAINTS REPORT

2020- 2021

1.0 Introduction

This is the complaints annual report for Southport and Ormskirk Hospital NHS Trust for the period 1 April 2020 to 31 March 2021. During this period there were 275,054 patient contacts with all services this was 32% lower than 2019/2020, 404, 534

The Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire, with one of the highest proportions of elderly residents within the country.

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

Patient care is at the heart of what we do and we are committed to improving the experience of our patients. We receive a significant amount of positive feedback about the services we provide but we know that we do not always get it right. It is important to us that people find it easy to raise their concerns and complaints with us and that they feel their feedback is welcomed and taken seriously.

The Trust recognises that every concern or complaint is an opportunity to learn and make improvements in the areas patients, their relatives and carers say matter most to them. Handling concerns and complaints effectively matters for people who use our services and it's important patients and their loved ones receive an explanation when things go wrong and we can demonstrate that a meaningful change has been made to prevent something similar happening to anyone else.

It is our aim to address concerns and resolve problems quickly and effectively at the point of care to ensure the satisfaction of all involved.

The Trust always seeks to apologise for any failings in care that has been provided and therefore we follow the principles of the duty of candour in complaints.

2.0 Performance Monitoring

Throughout 2020/21 the Patient Experience Team continued to triage all concerns. / complaints and wherever possible, resolved these locally with support from the operational clinical teams. The Complaints Team used the Complaints Grading Tool to assess what level of investigation should be carried out for all concerns/ complaints

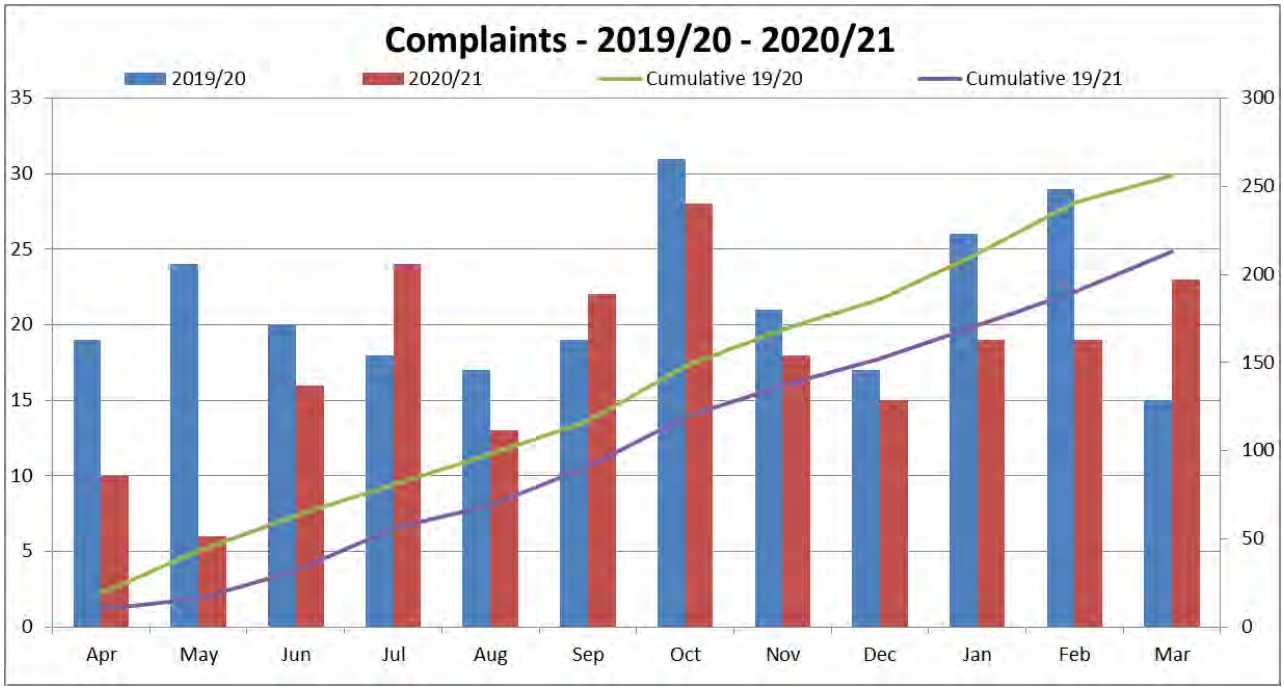
- **Level 1:** Issue brought to front line staff who able to resolve it by the end of the next working day.
- **Level 2:** Issue has minimal or relatively minimal impact to provision of healthcare or the Trust.
- **Level 3:** Potential to impact on service provision or delivery.
- **Level 4:** Issues that are significant with regard to standards, quality of care, denial of rights, personal injury.
- **Level 5:** Serious patient Safety issues.

2.1 Number of Complaints Received

Overall during 2020/21, the Trust received a total of 213 (full investigation) complaints compared to 256 in 19/20, which is a decrease of 16.8%. Unlike previous years, this indicator may not present a like for like comparison and the indicator may have been impacted by the following;

- The Covid-19 pandemic, which resulted in substantially fewer patients and visitors attending the Trust.
- Whilst there were fewer people attending the Trust, we saw tangible examples of where the inability to attend the hospital and visit caused worry and distress for family members.
- The support for the significant efforts of the NHS throughout the pandemic meant patients may be less likely to raise a complaint as they appreciated the pressure the NHS was experiencing.

Despite the extraordinary year, the introduction of the Patient Advice Liaison Service (PALS) has had a positive impact in de-escalating potential complaints and reaching early resolutions.



	Q1	Q2	Q3	Q4	Total
No of complaints received	32	59	61	61	213

2.2 Responding within Agreed Timescale

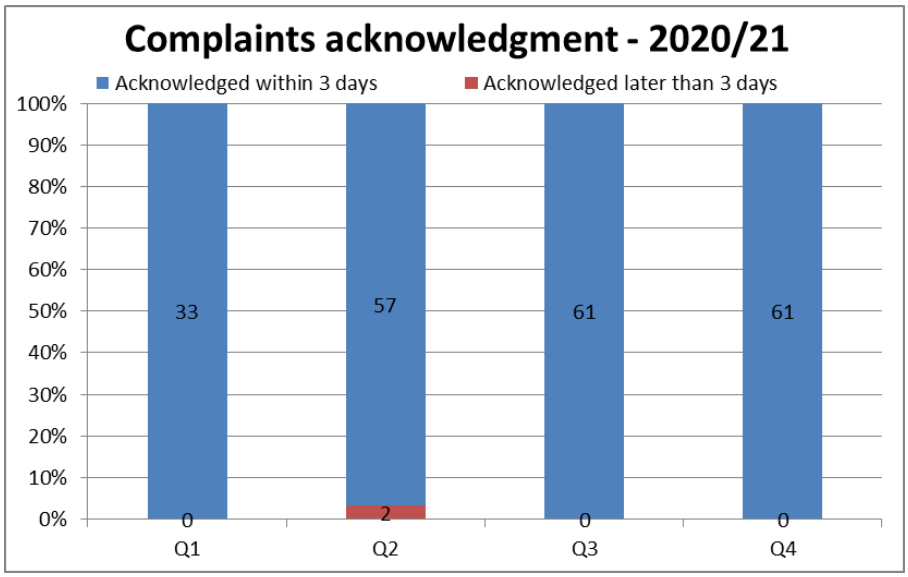
The table below shows the average number of working days between complaint receipt (and closure, for all complaints closed in 2020/21. The agreed timescale for dealing with complaints is 40 working days. A longer timescale is set only in exceptional cases – when a complaint is particularly complex.

Throughout 2020/21 it was evident that the average time to close has shown improvements but fluctuated and efforts in 2021/22 will focussed on consistently achieving this timescale.

Average no of days to close					
	QTR 1	QTR 2	QTR 3	QTR 4	Grand Total
Level 2 (Concern/Complaint)	9	7	6	5	6
Level 3 (Concern/Complaint)	58	32	37	49	45
Level 4 (Complaint)	36	32	63	55	53
Level 5 (Serious Complaint)	48	N/A	70	N/A	59
Total average days to close - Level 3 & above – Complaint	57	32	40	50	46

2.3 Complaint Acknowledgement

The NHS Complaints Regulations 2009 state that all complaints must be acknowledged with 3 working days of receipt. In Q2 the Trust acknowledged 97% of complaints which was due to 2 complaints being logged by the CBU's and not centrally, following this actions were put in place which have since resulted in 100% compliance.



2.4 (5) Day Contact with Complainant

Part of the role of the lead complaint investigator is to contact the Complainant within the first 5 days so we can offer support, clarify the main issues whilst trying to resolve the complaint.

The table below highlights there has been a steady increase in compliance throughout the year; this continues to be monitored by the Complaints Review Group (CRG).

Contact within timescale (5 days)				
CBU	**Q1**	**Q2**	**Q3**	**Q4**
Urgent Care	75%	59%	82%	87%
Women & Children's	67%	67%	80%	95%
Planned Care	40%	75%	71%	90%

2.5 Reopened Complaints

Reopened complaints are those where the complainant is not satisfied by the complaint response and requests further investigation, prior to any potential application to Parliamentary Health Service Ombudsman (PHSO).

Over the year there, has been a steady reduction of complainants not satisfied, this demonstrates the Trust is getting better at addressing the issues raised and complainants in general are satisfied by our responses. The 5 day contact with the complainant is in place so staff capture all areas and helps to reduce the number of re-opened complaints

Quarter	Complaints Received	Complaints Re-Opened*	% of Re-Opened Complaints
Q1	32	9	27%
Q2	59	14	24%
Q3	61	8	13%
Q4	61	7	11%

**The figures above relate to reopened complaints in the relevant reporting periods but it's important to note that the figures include 10 complaints which have been reopened but the original complaints were received in 2019.*

For the last year there has been a process in place where all complaints are reviewed by the Associate Director of Nursing in the Clinical Business Units and signed off by the Executive Director of Nursing.

The Executive Director of Nursing, Midwifery and Therapies is currently scoping out additional training for those staff who have complaints investigation within their work plans.

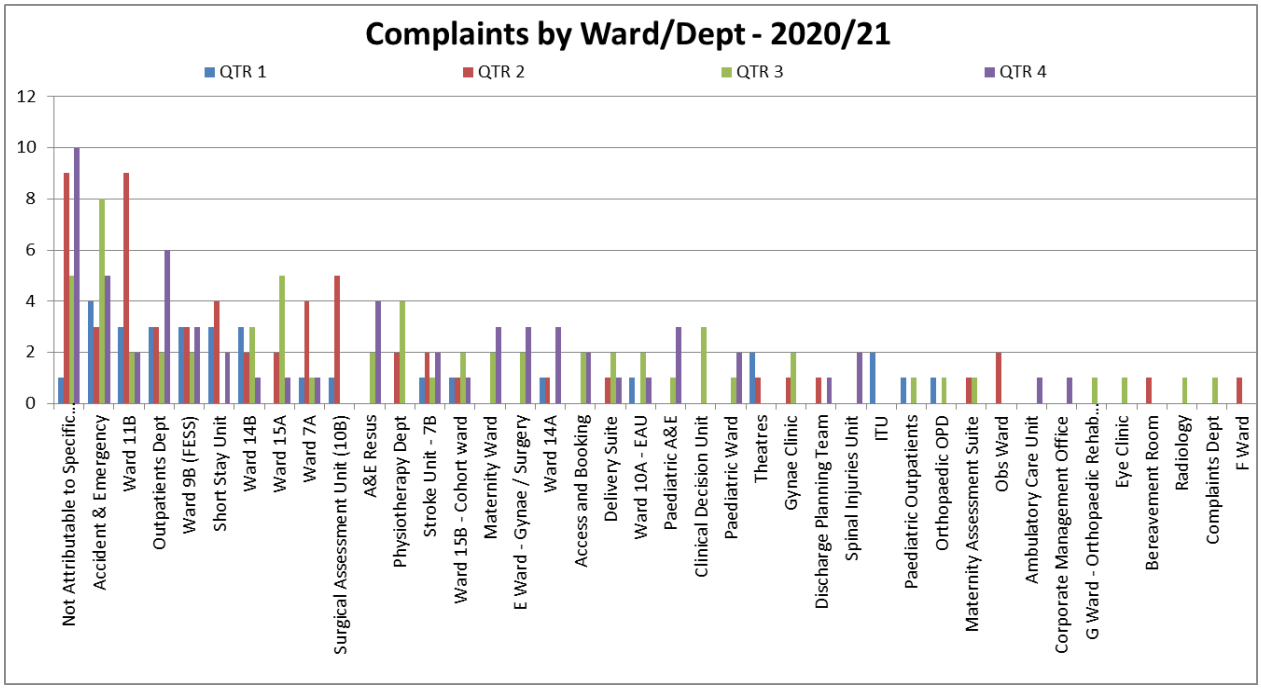
In November 2020, the Executive Director of Nursing, Midwifery and Therapies re-introduced the weekly Complaints Review Group (CRG) meeting as a support for staff and a guide on expectations. The meeting had been suspended due to Covid-19.

2.6 Complaints by Location

The graph below highlights the following;

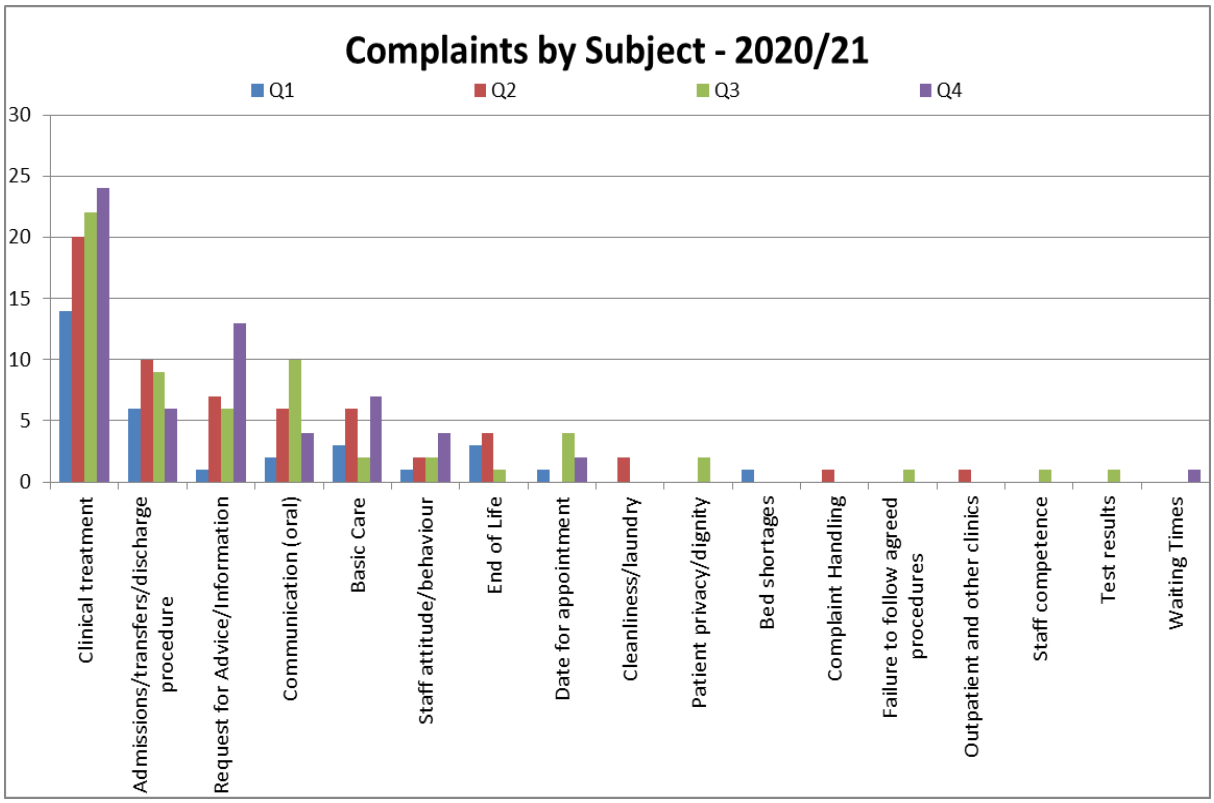
- The majority of the complaints were not attributable to a specific service
- On review of Datix the Accident & Emergency and the Outpatients Department had the same complaint themes; clinical treatment, poor communication, staff attitude.

- Ward 11B received the most complaints; however, there has been a notable reduction in Q3 and Q4 following some changes in leadership.



2.7 Complaint Subjects

All complaints are categorised by the subjects and sub-subjects contained within them therefore complaints can contain multiple subjects. The graph below shows the complaints by themes for 2020/21.



2.8 Themes from Complaints

Listed below are the top themes arising out of the complaints received during 2019/20
Over the year the highest 4 complaints themes remained the same:

Themes
Clinical Treatment
Admission/ transfer / discharge procedure
Request for advice/ information
Communication

2.9 Lessons learnt from complaints are shared at

- Ward and Clinical Business Unit (CBU) meetings
- At Board via patient stories
- Via Lessons Learnt Slides

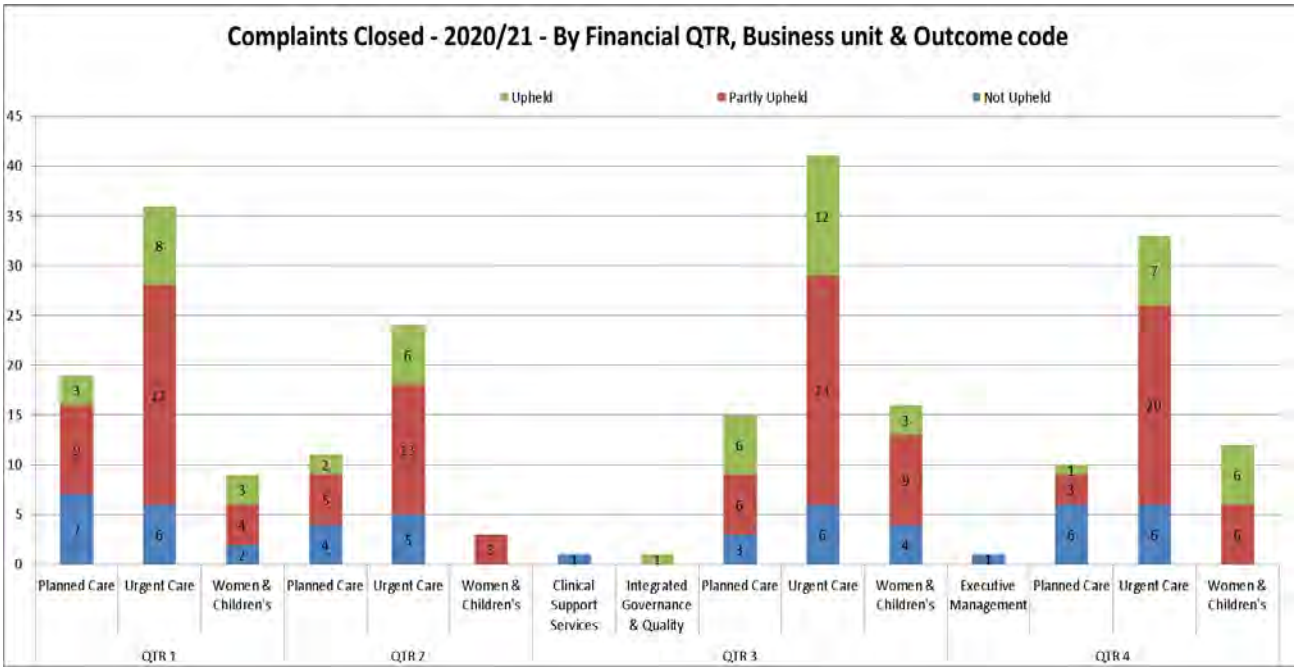
2.10 Closed Complaints

Throughout the Pandemic, teams continued to address the backlog of complaints from 2019/20, during 2020/21; 240 complaints were responded to.

Closed complaints 20/21				
Business Unit	**Q1**	**Q2**	**Q3**	**Q4**
Urgent Care	39	24	42	33
Planned Care	21	13	15	10
Specialist Services	9	3	17	12
Integrated Governance	0	0	1	1
Total	**69**	**40**	**75**	**56**
Grand Total				**240**

2.11 Outcome from Complaints

The table below highlights throughout 2020/21 the majority of the complaints were upheld / patially upheld.



2.12 Lessons Learned

- This year has been extraordinary in many ways but has emphasised how communication with relatives and carers is even more important during a pandemic when visiting is restricted. The lack of opportunity for visiting can create worry and angst amongst relatives when they are unsure of patients' current prognosis. The Trust put in place a range of activities to support proactive enhanced communication with families/carers, including the PICO team during wave 1, zoom calls to support face to face interaction and communication sheets to support communication.
- The Integrated Governance Team have introduced governance learning bulletins which includes learning from complaints and these are shared amongst all staff including at CBU and at ward level to share learning.
- Following an increase in concerns relating to discharge, the Trust undertook Quality Improvement (QI) events with wards and departments in relation to discharge. Each ward produced their own learning from what went well and where they could improve.
- As a result of the QI events:
    - We have produced a new discharge checklist and process which is currently in the trial phase;
    - Staff have been empowered to take their time to ensure they are satisfied all discharge checks are complete;
    - It's been agreed with external partners that any ambulance or patient transport will wait 15 minutes to ensure staff have the appropriate amount of time to undertake discharge checks safely.

- It was identified that wards/departments would benefit from additional ward clerk support during the winter given the increase in calls and communication as families have not been able to visit – this was put in place by the Trust to support communication with families.
- A new visual indicator is being trialled on wards to support staff in recognising patients approaching the end of life so that staff are aware and can support a calming environment
- Communication sheets are being trialled to support ongoing updates and communication with families and relatives.
    - Guidance throughout the pandemic has constantly evolved and Maternity are to continue to be clear and inform who can attend appointments with expectant Mothers. Where possible, any communication about appointments, such as text messages, will be more personalised to ensure clarity regarding who can attend.

2.13 End of Year Open Complaints

The table below shows open complaints; at the end of the year there were 43 open complaints.

CBU	Q1	Q2	Q3	Q4
Urgent Care	21	27	22	28
Planned Care	7	6	2	4
Women & Children's	1	5	4	11
Grand Total	**29**	**38**	**28**	**43**

2.14 Complaint Actions

By the end of the year there were 147 overdue actions which was 14 more than Q3 (133) and also an increase from 2019/20 when there were 39 overdue actions in Q4 19/20. The Integrated Governance Team are working with CBUs to improve this area and it's recognised that there has been additional pressure within Urgent Care particularly, which is in part due to the pandemic as well as vacancies for matrons and a patient safety manager which have since been recruited to. It's expected this position will improve in Q1 2021/22.

Total no of overdue complaint actions 20/21				
CBU	**Q1**	**Q2**	**Q3**	**Q4**
Urgent Care	93	107	104	109
Planned Care	15	15	15	17
Specialist Services	7	12	10	18
Integrated Governance & Quality	1	3	2	2
Estates & Facilities	3	2	2	1
Grand Total	**119**	**139**	**133**	**147**

3.0 Parliamentary Health Service Ombudsman (PHSO)

Complainants are advised of their right to apply to the PHSO for independent review if they are dissatisfied with the Trust's efforts to resolve their concerns. During 2020/21, there were 6 investigations were in progress; 1 was closed and 1 partially upheld; outcome details are highlighted below; 5 investigations were carried over to 2021/2022. T he PHSO activity was minimal during the pandemic, this will lead to an increase in completed investigations 2021/2022.

PHSO Activity					
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Investigated - not upheld	3	3	1	2	0
Investigated - fully upheld	0	0	0	0	0
Investigated - partially upheld	3	3	2	1	1
Complaint withdrawn by PHSO	1	1	1	3	0
No decision made yet - carried forward	5	4	4	6	5
Total Number	12	11	8	12	6

3.1 Partially Upheld Complaint

In 2017 the patient attended the Accident and Emergency Department they were not treated in a timely manner and there were concerns about the clinical management as a result. It was noted that the Trust had moved from performing below the national average in the 4-hour A&E targets for the months of August 2017 & 2018 to above average in August 2019. It also noted that for April, May and June 2020 A&E had been above average. The PHSO were satisfied that this was sufficient evidence to show that all the changes made to the A&E Department had had a positive effect.

3.2 How We have Improved Our Services

The Trust has implemented the following;

- The Clinical Decision Unit (CDU) was introduced within the A&E Department. This continues to provide an area for patients who require longer periods of observation. It also reduces pressure within the department whilst supporting flow and capacity
- An Ambulatory Care Unit (ACU) was opened and is able to stream GP admissions
- The front entrance for the A&E Department has been redesigned to include a dedicated Ambulance Triage and increased capacity for walk in triage
- The Trust continues to avoid caring for patients in the corridor, which is important to ensure patients are cared for in the safest and most appropriate place.
- The A&E Department now has 2-hourly multidisciplinary huddles where patients are discussed and any delays are escalated to the appropriate clinical lead
- The Trust has reviewed its performance standards for clinical reviews and its escalation process in the event of delays

- The Trust has an AKI Consultant lead.
- We have developed a new AKI pathway which is part of the Advancing Quality Alliance initiative.

4.0 Patient Advice Liaison Service (PALS)

The PALS service was a new addition to the Trust to support patients and was introduced in August 2020; it has proved to be a great asset to the Trust.

Since the introduction there has been an increase in activity with 476 concerns / information requests received compared to 175 from the same quarter last year (2019/20). This increased activity demonstrates this service is visible and accessible. The service has been well received by patients, families and staff with extremely positive feedback.

The increased numbers of concerns and information requests related to the following areas; these remain the same as the previous quarter

- Issues from the Covid-19 pandemic
- Missed appointments
- Missing patient property – a review of this area is ongoing and being addressed

	Q1	Q2 – PALs service established – September 2021	Q3	Q4	Total
No of Concerns/Information Requests	146	237	397	476	1256

4.1 PALS Service Good News Stories

There has been multiple positive interactions with patients , their relatives and families to support communication but below are some brief examples of support given.

- Numerous families have been supported to make contact with their relative, including for example zoom calls for patients approaching the end of their life.
- Patients were signposted to departments
- Patients were assisted with appointment issues
- A mobile phone was found and returned to a patient
- A patients house keys were provided to a family

5.0 Covid -19 Impact on NHS Complaints

Covid-19 put tremendous pressure on the NHS meaning that we were less able to respond to complaints as we would wish to. The Parliamentary and Health Service Ombudsman (PHSO) decided that additional burdens should not be placed on the NHS during a time of national emergency so they were not accepting any new health complaints or processing existing ones which involve contact with the health service.

Whilst acknowledging the immense pressure on clinical colleagues, a decision was taken by the Trust to continue to aim to respond to complaints within 40 days. Recognising that investigations would not be a priority for front line staff, it remained important that the voices of our patients were still heard. Whilst management and investigation of complaints continued it was recognised that over time it would be inevitable that the Trust governance staff would have to deviate from processes and procedures due to the immense pressure on our clinical staff. A number of steps were taken by the Patient Experience Team to support clinical colleagues.

- The Team investigated and responded to the complainants on behalf of the business units
- Reviewed and addressed the back log of overdue complaints

As the Trust enters 2021/22 the Patient Experience Team will continue to triage all complaints and wherever possible will try to resolve these locally with support from service.

6.0 Compliments

Throughout 2020/21, compliments were recorded on DATIX and the figures presented below. It's anticipated that the figure will be higher as we know compliments are often sent directly to the wards via thank you cards and not all make it onto DATIX.

	Q1	Q2	Q3	Q4
No of Concerns/Information Requests	**82**	**146**	**89**	**76**

7.0 Evidence of Assurance with Trust Complaints Management Policy

Compliance with complaints management good practice is monitored within the organisation through, governance groups and forums attended by patients, carers and volunteers. It also monitored at the weekly Complaints Review Group led an Executive.

Externally, compliance is monitored by CQC (Care Quality Commission) inspections and we were inspected by CQC in March 2021 where CQC reviewed complaints in the Urgent Care Business Unit and noted *'The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.'*

In addition compliance is also monitored externally via the PHSO's (Parliamentary and Health Service Ombudsman) review of individual complaints.

The Policy for Complaint management is currently under review.

8.0 Development of Trust's Complaints Process

PALS was introduced in August 2020, this service has provide invaluable as they are

- responding timely to concerns and reaching resolutions
- visible and accessible within the hospital
- Receiving excellent feedback from staff, patients and visitors
- Receiving more and more contacts, this demonstrates this service is much needed
- Assisting the wards with patient/ visitor queries, thus the wards have more time to care for patients.

9.0 Conclusion

The last year has been particularly difficult for the Trust due to the pandemic but there continues to be improvement in the management of complaints and concerns across the Trust.

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Maternity Services Trust Board Report

Presented by Lynne Eastham Associate Director of Midwifery

and

Mrs Uma Karthikeyan, Clinical Director

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Overview

- Ockenden Inquiry
- Saving Babies Lives
- Perinatal Mortality
- Support for Black, Asian & Minority Ethnic Women
- Progress of ‘Better Births’ (2016) regarding delivery of Continuity of Carer
- CNST Maternity Incentive Scheme
- Safety Champions

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Ockenden Inquiry

12 Urgent Clinical Priorities - Demonstrated partial compliance with 4 of these priorities

- SI's are shared with Trust Boards at least monthly
- Women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance
- A risk assessment must be completed and recorded at every contact.
- Implementation of a Perinatal Clinical Quality surveillance model

The Board is requested to note the minimum dataset recommended on Slide 4

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Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

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Ockenden Inquiry

- An ‘Ockenden Portal’ will be opening on Monday 17th May 2021 for 4 weeks, overseen by NHSE/I where each Maternity provider will submit evidence to support progress and compliance against the 12 Urgent Clinical Priorities
- Maternity Improvement Group & Board
- LMS Assurance meetings monthly
- LMS weekly check & support meetings

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Saving Babies Lives

- Supports Safety Agenda and ambition to reduce perinatal and infant mortality by 2025
- 5 Elements:
  - Reduce smoking
  - Surveillance for foetal growth restriction
  - Awareness of reduced foetal movements
  - Effective foetal monitoring during labour
  - Reducing pre term birth

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Saving Babies Lives

Can demonstrate compliance against all elements with the exception of Element Two:

Whilst most of the element is embedded, GROW should be used for plotting and measuring growth of the fetus as there are risks of errors associated with manual plotting. GROW Can also be used to audit.

There has been a delay in implementing GROW due to System C upgrading the current Maternity Information System. Expected date for implementation is mid - May 2021.

Failing this a manual audit of 40 records will be carried out to ensure full compliance to support CNST safety action 6

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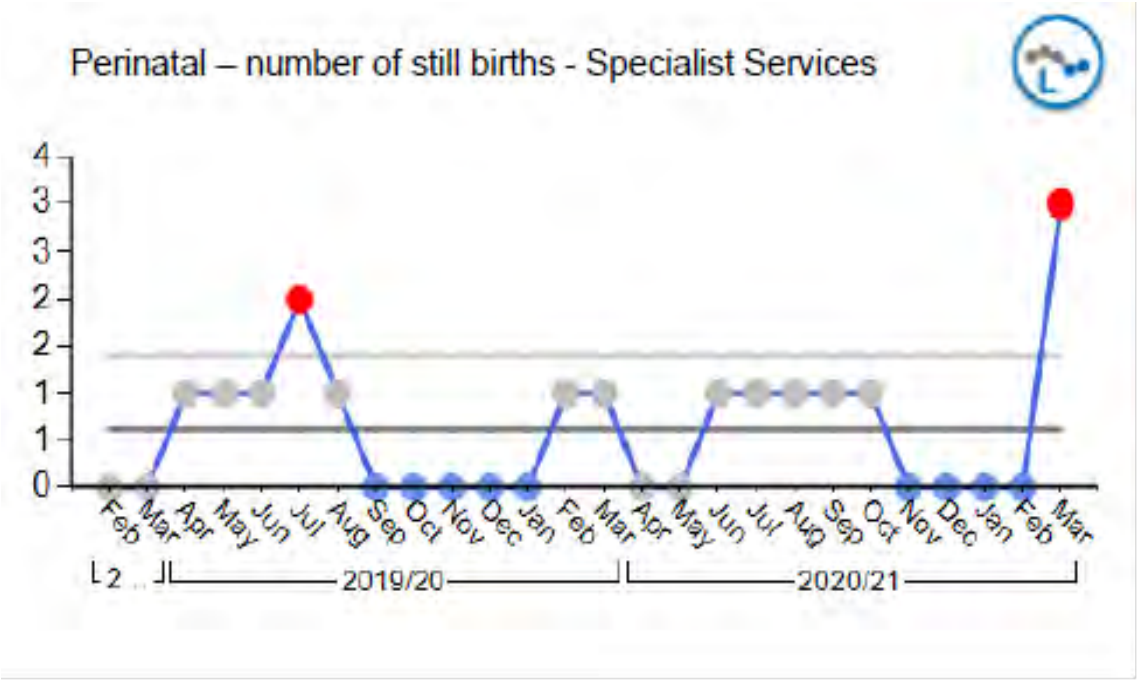
Perinatal Mortality



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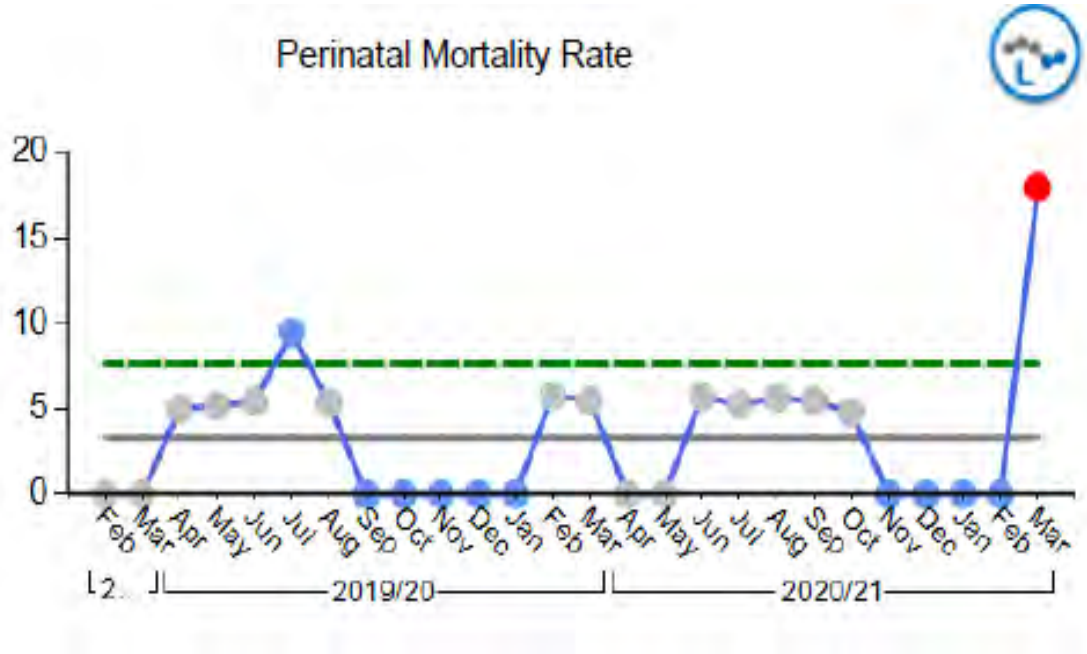
Perinatal Mortality



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Perinatal Mortality

- Perinatal mortality includes stillbirths and neonatal deaths in the first week of life.
- All stillbirths and deaths are reviewed at the weekly patient safety meetings and reported to SIRG via a 72 hour review report.
- One StEIS incident (March 21).

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Support for Black, Asian & Minority Ethnic Women

Covid-19:

- Black, Asian & Minority Ethnic Women groups disproportionately and make up more than half of pregnant women admitted to hospital
- Asian women are 4 times more likely than white women to be admitted to hospital
- Black women are eight times more likely than white women to be admitted to hospital

Chief Midwifery Officer 4 equity actions

- Policy to support care and management
- Communications
- Vitamin D
- Data collection

Action plan developed and complete

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

Delivery Date	Percentage of women on Pathway
March 2022	Nationally set trajectory is 35% for March 2022 To include women from for black, Asian and multiple deprivation areas
Onwards	progression to CoC being the default model of care offered to all women by March 2023
Current position	11%

- Organisational Change Process
- National Maternity Bid
- Birthrate Plus review
- Action plan in place

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CNST

- Year 3 of CNST Incentive Scheme
- 3 amendments made to Safety actions (Oct, Jan, March)
- Submission Date 15 July 2021
- 6 Safety Action are now compliant as follows
- 4 Safety Actions are on track to complete in June 2021

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CNST

Issues

Safety Action 4 – Workforce

- Neonatal and anaesthetic workforce requirements are not fully compliant with the safety action
- If this is not met, an action plan to address deficiencies is required and agreed at board level. This is currently in development with a plan to report to Board June 2021

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NHS Trust

CNST
Role of Board

- Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.
- Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk by 12 noon on Thursday 15 July 2021.

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Safety Champions Update

- Meetings are held bi-monthly to discuss safety issues
- Visible leadership

Concerns Raised:

- Staffing level pressures since March 2021
- Feedback that lessons learnt are not always balanced
- Leadership
- Temperature on the maternity unit

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Safety Champions

Actions taken:

- Senior leadership visibility increased /helicopter view
- Positive messages
- Ice and water machines
- Maternity SCOPE Values awards

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Patient Experience and Involvement

- Partnership with the Maternity Voices Partnership
- Introduced on line bereavement support group
- Grant for mental health support for families
- Developing and updating our website with videos of our team informing women of their role
- Developed a questionnaire based on themes from complaints to support developing our Quality priorities

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Key Priorities

- Completing the 10 CNST safety actions
- Evidence submission for Ockenden and continued progress
- Implementation of continuity of carer model
- Establish patient experience strategy and staff recognition approach for the CBU

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB094/21**	**FOI Exempt**	**NO**
Report Title	**MATERNITY SERVICES REPORT – CNST**		
Executive Lead	Bridget Lees Director of Nursing, Midwifery & Therapies		
Lead Officer	Lynne Eastham, Head of Midwifery/Nursing		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To provide the Committee with an update on progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme 10 safety actions

Executive Summary

This paper provides an update on compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme which supports the Safer Maternity Care Ambition through delivery of safer maternity care.

The maternity incentive scheme was launched in 2017/2018 and offers up to 10% rebate of the Maternity premium for Trusts that can demonstrate compliance against 10 safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services. Due to the impact of Covid19, the scheme was temporarily put on hold and was relaunched on the 1 October 2020 with a deadline for submission of achieving the 10 safety actions by the 20 May 2021. However, this guidance and the standards were subsequently updated, and a new submission deadline of 15 July 2021 was announced. The action plan outlines status as well as intervention required to progress to compliance.

- 6 Safety Actions are now compliant as follows:

Safety Action 1	Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard	Compliant
Safety Action 2	Are you submitting data to the Maternity Services Data set to the required standard?	Compliant
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant
Safety Action 8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Compliant
Safety Action 9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Compliant
Safety Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to resolution's notification scheme?	Compliant

- 3 Safety Actions are on track to complete in June 2021

Safety Action 4 – Workforce
Neonatal and anaesthetic workforce requirements are not fully compliant with the safety action. If this is not met, an action plan to address deficiencies is required and agreed at board level. This is currently in development with a plan to report to Board June 2021

Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	On track
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	On Track
Safety Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	On track

Safety Action 3 – Transitional Care
We are not compliant with 1 out of the 3 elements of this safety action related to transitional care

Safety Action 3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into the Neonatal Units programme?	Not Fully Compliant

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission. Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on Thursday 15 July 2021**.

Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Recommendations

The Board is asked to **receive** and **note** the areas of non-compliance as well as the requirement to certify the Trust's declaration following consideration of the evidence provided.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Lynne Eastham, Head of Midwifery/Nursing	Lynne Eastham, Head of Midwifery/Nursing

SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST

ACTION PLAN

RED	Little or No Progress Made
AMBER	Moderate Progress Made
YELLOW	Actions Almost Completed
GREEN	Completed

SOUTHPORT & ORMSKIRK HOSPITAL – Maternity Incentive Scheme – Year Three

Safety Action No	Required Standard	Current RAG rating of compliance	Evidence
1. Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard			
	All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	**Compliant** Matron and identified leads along with Bereavement Midwife support process	CNST will check PMRT data
	A review using the PMRT of 95% of all deaths of babies suitable for review using the PMRT from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021	**Compliant** PMRT tool used to review all deaths in place from prior to dates required	DATIX 72 hour review Minutes of SIRG PMRT tool reporting Quarterly reporting to Board Minutes of Board Minutes of Safety Champions meeting
	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15	**Compliant** Reports completed within timescales	Evidenced by PMRT tool reporting Report completed within timescales

Compiled By: L Eastham, Associate Director of Midwifery
Date: May 2021

	March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021		
	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions	**Compliant** All parents are informed via face to face and by letter and invited to attend review meeting or send in questions to be included Bereavement Midwife in post who maintains contact	Record of duty of candor PMRT reports
	Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	**Compliant** Quarterly reports presented at Trust Board and Maternity Safety Champions meetings	Minutes of meetings
2. Are you submitting data to the Maternity Services Data set to the required standard?			
	At least two people registered to submit MSDS data to SDCS Cloud and still working in the Trust on Saturday 31 October 2020 (complete- all Trusts have registered).	**Compliant**	Two identified from Business Intelligence Team
	MSDSv2 webinar attended by at least one colleague from each Trust in January/February 2020 (complete – all Trusts attended).	**Compliant**	Two identified from Business Intelligence Team

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	Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	**Compliant**	E Mail evidence discussing concerns that Trust may not comply due from issues with Maternity Information System with LMS - Trust conformed prior to deadline
	Made a submission relating to August 2020 - December 2020 data, submitted to deadlines October 2020 - February 2021	**Compliant**	E Mail evidence from LMS that that Trust conformed prior to deadline
	December 2020 data included all following tables MSD000 MSDS Header MSD001 Mother's Demographics MSD002 GP Practice Registration MSD101 Pregnancy and Booking Details MSD102 Maternity Care Plan MSD201 Care Contact (Pregnancy) MSD202 Care Activity (Pregnancy) MSD301 Labour and Delivery MSD302 Care Activity (Labour and Delivery) MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby) MSD901 Staff Details	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood). (MSD101)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month. (MSD101)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month (MSD001)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital

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	December 2020 data contained valid ethnic category (Mother) for at least 80% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained antenatal continuity of carer plan fields completed for 90% of women booked in the month. (MSD101/2)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
	December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month. (MSD101/2)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital
3 Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into the Neonatal Units programme?			
	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.	**Not Compliant** HRG XA04 refers to transitional care of the neonate The pathway needed is not in place. criteria are used to assess eligibility for TC from birth include: • Any baby born 34 to 35+6 weeks gestation who do not need to be admitted to a NNU • Any baby with a birth weight above 1600g or below 2000g • Any baby with risk factors for sepsis who require IVAB but are clinically stable • Any baby with a congenital abnormality who is likely to require tube feeding • Any baby at risk of haemolytic disease, requiring immediate phototherapy. • Haemolytic disease requiring enhanced phototherapy	**Actions taken to date:** Transitional Care Policy written and agreed with Maternity & Neonatal Team Staffing Model Developed and Statement of Case Presented at Business Planning and PIDA Pathways in place to Avoid Term Admissions to NNU Staffing levels review including support for transitional care model undertaken and plan to present to Board On risk register

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		• Inability to maintain temperature following re-warming • Inability to establish full suck feeds and therefore the need for an NGT • Significant Neonatal Abstinence Syndrome (NAS) symptoms, requiring oral medication or additional feeding To support Transitional Care increase to neonatal staffing is required in line with BAPM	
	A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: closures or reduced capacity of TC, changes to parental access, staff redeployment, changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	**Compliant** MDT team review of all term admissions to NNU and feedback lessons learnt. Action taken are reported at the Maternity Care Forum	Outcome of reviews Actions plans and lessons learnt. Minutes of meetings
	An action plan to address local findings from Avoiding Term Admissions into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.	**Compliant** MDT team review of all term admissions to NNU and feedback lessons learnt. Action taken are reported at the Maternity Care Forum and Safety Champions Meeting	Outcome of reviews Actions plans and lessons learnt. Minutes of meetings
	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	Pathways in place to avoid term admissions to NNU including Jaundice, infection and hypoglycaemia which are now embedded. Respiratory pathway in place which is now being followed but still needs embedding. These have all reduced admissions to the NNU	Action Plan Minutes of Safety Champions meeting
4.	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**		
	Anaesthetic medical workforce	**Expected Date for Compliance June 2021 – ON TRACK**	The Trust is not compliant with requirement of 1.7.2.5 but an

	An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	**1.7.2.5** Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff A copy of rotas and lists showing dedicated theatre lists with a named consultant, or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision, with no other clinical commitment	Action Plan is being developed in line with the recommendations from the CNST safety action to demonstrate how we will be working to meet these standards which will meet compliance Trust Board Level agreement
		Compliant **1.7.2.1** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.	Copy of rotas and process of delegation
		Compliant **1.7.2.6** The duty anaesthetist for obstetrics should participate in labour ward rounds	Copy of Rotas
	Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	**Compliant** Tier 1 A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.	Copy of Rotas
		Partially Compliant Expected Date for Compliance June 2021 – ON TRACK Tier 2 doctor allocated to the NNU during working week.	Action Plan is being developed in line with the recommendations from the CNST safety action to demonstrate how we will be working to meet these standards which will meet compliance

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		However at weekend long day doctor covers Paediatrics as well	Trust Board Level agreement
	Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations	**Partially Compliant Expected Date for Compliance June 2021 – ON TRACK** Staffing review completed Workforce tool completed Action plan being developed	Trust Board needs to formally record in the Trust Board minutes the compliance to service specification standards annually using the neonatal clinical reference group nursing workforce. For units that do not meet the standard, an action plan should be developed to meet the standards ans signed off by the Trust Board and copy submitted to the ODN
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
	A systematic, evidence-based process to calculate midwifery staffing establishment is completed	**Compliant**	Bi annual paper submitted to Board
	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	**Compliant**	Bi annual paper submitted to Board
	All women in active labour receive one-to-one midwifery care	**Compliant**	Bi annual paper submitted to Board
	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).	**Compliant**	Bi annual paper submitted to Board
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?			
	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019	**Compliant**	Clinical Effectiveness Committee minutes Trust Q&SC Minutes Trust Board report
	Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their	**Expected date for Compliance June 2021 –** Element Two not fully embedded	

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	commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network		
	The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.	**Compliant**	All survey submissions to region
	Element one: Reducing smoking in pregnancy A. Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. C. Percentage of women where CO measurement at 36 weeks is recorded. Threshold of successful implementation is 80% compliance	**Compliant** Recording of CO2 monitoring completed via Maternity Information System at booking and at 36 weeks gestation and included in MSDS to NHS Digital CO2 monitoring was temporarily paused during COVID and has since recommenced in March 2021 Prior to pausing CO2 recording was over 80% Since recommencing is under 80% but improving with trajectory for recovery In line with CNST guidance during pausing of CO2 monitoring percentage of women asked whether they smoke at booking and at 36 weeks is completed on a quarterly basis with over 95% compliance	E Mails shared with CCG's Audit NHS Digital
	Element two: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS)	**Expected date for Compliance June 2021 –** Growth of the fetus is measured and monitored by manual plotting of measurements during antenatal assessments. However, there are risks of errors associated with manual plotting.	

	and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition the Trust board should specifically confirm that within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case the Trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice	GROW is an electronic tool which interfaces with the Maternity Information System to assess fetal growth by using customised growth charts bespoke for each woman. There has been a delay in implementing GROW due to System C upgrading the current Maternity Information System. Expected date for implentation Mid May 2021 If not successful manual audit will be needed of 40 cases	
	Element three: A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG. Note: The SNOMED CT code is still	**Compliant**	Audits

	under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element three indicators. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.		
	Element four: A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. B. Percentage of staff who have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training: Obstetric consultants All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub specialty trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.	**Compliant**	Training database
	Element 5: Reducing pre term births A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth**.** B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	**Compliant**	Clinical Guidelines Audits

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	In addition, the Trust board should specifically confirm that within their organisation: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If thisis not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.		
7.	**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?**		
	Terms of Reference for your MVP	**Compliant**	Copy of Terms of reference
	A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback	**Compliant**	Examples of Minutes of Meetings
	Evidence of service developments resulting from coproduction with service users	**Compliant**	Minutes of meetings and evidence of changes and partnership working
	Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses	**Expected date for Compliance June 2021 – Need evidence from chair**	Evidence from chair
	Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	**Compliant**	Minutes of meetings Written statement from chair
8.	**Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**		

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	Covid-19 specific e-learning training has been made available to the multi-professional team members?		
	Team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019	In the current year CNST have removed the threshold of 90%. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.	
	there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted		Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, MDT training when this is permitted.
9.	**Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?**		
	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.	**Compliant**	Pathway in place Visible to staff in clinical areas Minutes of MVP meetings demonstrating how pathway works
	Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	**Partial Compliance – On track**	Staff can verbalise that they have had opportunity to raise concerns Newsletter developed to feedback to staff outcomes Board safety Champion walkabouts now in place and Ill include update in Maternity Trust Board report
	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or	**Compliant**	COC action plan CoC SBAR Minutes of Safety Champions meeting Minutes of PIDA Trust Board minutes quarterly

	continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.		
	Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to:	**Compliant**	DATIX reporting Patient safety meetings PIDA Metrics
	i) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes.	**Compliant**	
	ii) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	**Compliant**	Safety champions meeting minutes Maternity Trust Board report TQ&S Minutes
	iii) The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf	**Compliant**	Safety champions meeting minutes Maternity Trust Board report TQ&S Minutes
	iv) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups and considered the recommendations and requirements of II, III and IV on I.	**Compliant**	Letter circulated 22 June 2020 and action plan developed in response Action plan shared with MVP
	The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: • Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns • Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with	**Compliant**	Representation at patient safety networks Supportive of safety collaborative work and improvement work
10	**Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to resolution's early notification scheme?**		

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	Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	**Compliant** Qualifying incidents are reported to HSIB. NHS Resolution notified by HSIB as required.	
	Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.	**Compliant** Qualifying incidents are reported to HSIB.	DATIX HSIB monthly reports
	c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and	**Compliant** Reference included in HSIB reports Duty of candour letter	DATIX HSIB Reports
	2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**Compliant** Duty of Candour competed in line with requirement	DATIX reporting PIDA

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Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB094/21**	**FOI Exempt**	**NO**
Report Title	**MATERNITY SERVICES REPORT – PERINATAL MORTALITY REVIEW TOOL**		
Executive Lead	Bridget Lees Director of Nursing, Midwifery & Therapies		
Lead Officer	Lynne Eastham, Head of Midwifery/Nursing		
Action Required	☐ **To Approve** ✓ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

To inform and assure the Board

Executive Summary

All perinatal mortality deaths eligible are notified to MBRACE-UK within seven working days. The National Perinatal Mortality Tool (PMRT) is used to review eligible deaths. The criteria for eligible deaths is:

- All late miscarriages/ fetal loss (22 to 23+6 weeks)
- All stillbirths (From 24 weeks)
- Neonatal Deaths (Up to 28 days after birth)

The review takes place by the multi-disciplinary team including external representation. Parents are informed that the review is taking place and are invited to ask any questions which can be included in the review. Contact is maintained with the parents by the Bereavement Midwife

CNST Safety Action 1 states that the Trust Board receive a quarterly report including details of deaths reviewed and consequent action plans

This report is for the reporting period November 2020 to January 2021 inclusive

PMRT

For this period there was 1 late fetal loss (DATIX 89188). This was a woman with previous history of two small for gestational age babies who contacted Triage in her third pregnancy at 22 weeks gestation with history of ruptured membranes. On admission she was confirmed as in labour and baby delivered with no signs of life. Death due to extreme prematurity and infection (acute chorioamnionitis).

Actions/Lessons Learned

Parents contributed to review of case. The review group identified care issues which they considered would have made no difference to the outcome for the baby and/or mother. This included:

- Review of guidelines for resuscitation. Recently published guidance from BAPM for infants delivering at 22 weeks gestation
- Parents weren't given opportunity to take baby home. This has now been added to bereavement care pathway

Membership or PMRT Reviews

No external representation was available for this case review. This is due to competing priorities of clinicians and process for attending is not mandatory. In view of the Ockenden Review this is now being considered by the LMS

Southport and Ormskirk Hospital NHS Trust

Recommendations	
The Board is asked to **note** the PMRT report and the actions taken.	
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:**
Lynne Eastham, Head of Midwifery/Nursing	Lynne Eastham, Head of Midwifery/Nursing

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Southport & Ormskirk Hospital NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/11/2020 to 31/1/2021

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *2*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
1	0	0	1	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
1	0	0	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	1	--	--	--	--	1
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*1*	*0*	*0*	*0*	*0*	*1*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	0	0	0	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	1	0	0	0	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	0	0	0	0	1
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	1	0	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	1	100% (1)
Admin/Clerical	1	100% (1)
Bereavement Team	2	100% (1)
External	0	0%
Management Team	0	0%
Midwife	5	100% (1)
Neonatal Nurse	0	0%
Neonatologist	1	100% (1)
Obstetrician	4	100% (1)
Other	0	0%
Risk Manager or Governance Team	2	100% (1)
Safety Champion	3	100% (1)

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**1 causes of death out of 1 reviews**
	Extreme prematurity and infection.
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
Dissemination of a Flash report to inform all relevant clinicians of the changes to Guideline.	1	No action entered
The opportunity to take their baby home was not offered to the parents	1	For Bereavement specialist Midwife to update the current pregnancy loss pathway to include discussion about taking baby home.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	1	No action entered
The baby had to be transferred elsewhere for the post-mortem	1	No action entered
Update the current Obstetric guidelines to reflect the BAPM guidance to consider active resuscitation from 22 weeks 0 days	1	For a review of the Obstetric Guideline

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Communication - Written communication	1	The opportunity to take their baby home was not offered to the parents
		Dissemination of a Flash report to inform all relevant clinicians of the changes to Guideline.

NHS
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NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB095/21**	**FOI Exempt**	**NO**
Report Title	**FREEDOM TO SPEAK UP REPORT QUARTER 4 REPORT**		
Executive Lead	Bridget Lees, Executive Director of Nursing Midwifery & Therapies		
Lead Officer	Lynne Barnes; Deputy Director of Nursing Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required	☐ **To Approve** ✓ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

This report identifies the number of concerns raised through Freedom to Speak Up Service (FTSU) during the period 1 January until 31 March 2021

Executive Summary

This report provides assurance of the significant improvement journey that *speaking up* has made since the National Guardian's Office case review in 2017. Over the quarter, 14 concerns were raised through FTSU and the themes of the concerns raised include:

- Safety during Covid-19
- Review of processes
- Management issues/Leadership
- Nepotism and staff being treated differently
- Treatment of staff by managers
- Bullying behaviours
- Ensuring all staff receive Covid-19 vaccine and mask fit testing
- Future of service

Recommendations

The Trust Board is asked to **receive** this report as assurance.

Previously Considered By:

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

Strategic Objectives

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

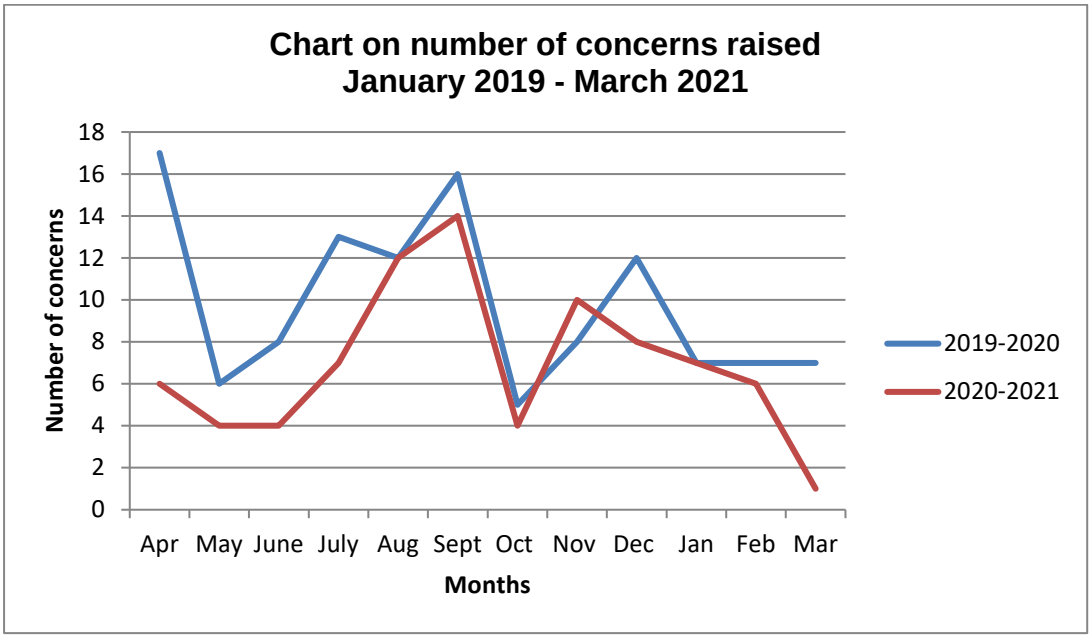
Prepared By:	**Presented By:**
Lynne Barnes and Martin Abrams	Martin Abrams, (FTSU) Guardian

Introduction

The report provides assurance that people can raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place for staff to do this safely and confidently, knowing that appropriate action will be taken.

1. Report on Submission to National Guardians Office

Quarter 4	1 January – 31 March 2021
Date to be submitted to NGO:	20 April 2021
Date National Data to be published:	To Be Confirmed
Number of Concerns Raised	**14** (January 7, February 6, March 1) 11 of these were directly with the Freedom to Speak Up Guardian (FTSUG) and three were raised through FTSU Champions. When concerns are raised directly with FTSU champions, the FTSUG always gives support and advice, often meeting those who raise the concern, and sometimes being used in a consultative role.



Number of Concerns Raised

During Q.4 11 of concerns were directly with the Freedom to Speak Up Guardian (FTSUG) and three were raised through FTSU Champions. When concerns are raised directly with FTSU champions, the FTSUG always gives support and advice, often meeting those who raise the concern, and sometimes being used in a consultative role.

2. Themes of Concerns

For reasons of confidentiality, only general themes are recorded within this report. During the quarter these have included:

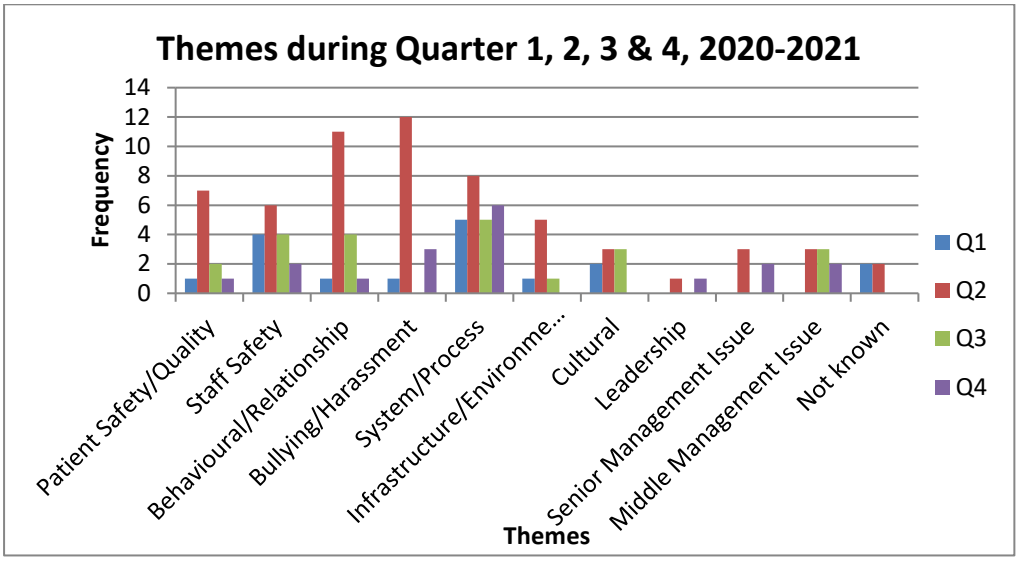
- Safety during Covid-19
- Review of processes
- Management issues/Leadership
- Nepotism and staff being treated differently
- Treatment of staff by managers/bullying
- Ensuring all staff receive Covid-19 vaccine and mask fit testing
- Future of service
- Patient safety

In terms of proportion, the table below expresses concerns raised as a percentage:

Theme	% this Quarter
Patient Safety / Quality	5.56%
Staff Safety	11.11%
Behavioural / Relationship	5.56%
System / Process	33.33%
Senior Management issue	11.11%
Bullying/Harassment	16.66%
Leadership	5.56%
Middle Management issue	11.11%

Graph of Themes for Year to Date

Below is a graph expressing the themes of concerns raised over the year. Please note the themes at the bottom of the graph are the categories required by the National Guardian's Office for submission.



3. Anonymous Concerns

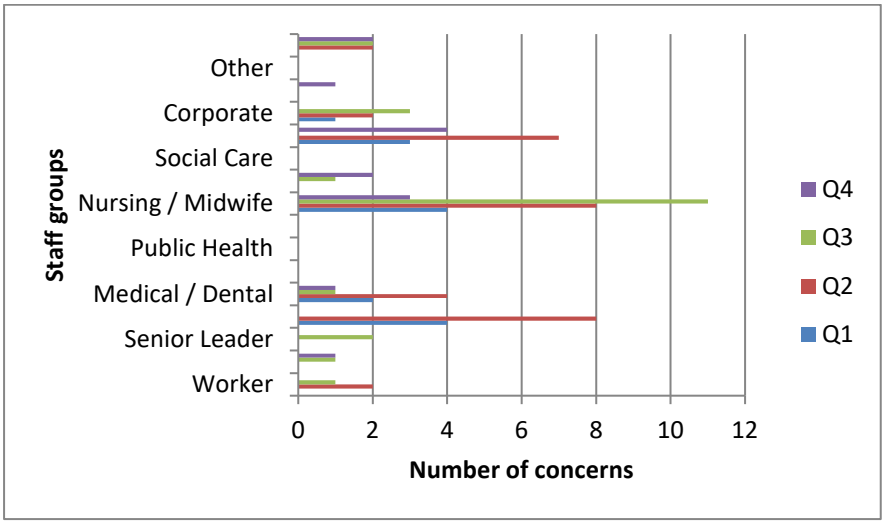
During Quarter 2, there were two anonymous concerns. This is where the person raising the concern cannot be contacted as there are no contact details, e.g. anonymous letter / phone call. There were also two concerns where the person does not want their name associated with the concern as they were worried about repercussions.

4. Staff Groups Raising Concerns

Concerns this quarter have been raised by a cross-section of staff, as shown below. These follow the definition of the National Guardian's Office.

Staff Group	% this Quarter
Manager	7.14%
Not known	7.14%
Medical / Dental	7.14%
Nursing / Midwives	21.43%
HCA	14.29%
Admin	28.57%
Anonymous	14.29%

5. Staff Groups Raising Concerns Over the Year



6. Situations where detriment was expressed because of speaking up

In the last quarter there have been no new situations of detriment highlighted.

7. Feedback Post Raising Concerns

The National Guardian's Office requires the FTSUG to invite those who have raised concerns, and have had their concerns closed, to offer feedback, specifically:

- Would they use the FTSUG again to raise a concern?

- Would they like to offer further comments about the service or the process?

During this quarter feedback was received from three people, one verbal, who have raised concerns with the FTSU service. All of the feedback received was positive. Examples are as follows:

- *We are very grateful for the help he has already given which was very useful.*
- *I was delighted with the fast response and would not hesitate to contact them again in the future.*
- *Thank you. I was very pleased with the service.*

8. Changes as a Result of Speaking Up

One of the major recurring themes that continues to be apparent through FTSU is that of the behaviours being displayed by some staff which are not in keeping with the SCOPE values of the trust. The response to this is ongoing and I understand a trust wide piece of work is beginning on this soon.

Recent conversations have also highlighted FTSU as providing:

- Enhanced safety during Covid-19
- Review of processes
- Improvement of management issues/leadership
- Positive response to issues of nepotism and staff being treated differently
- Improvement of treatment of staff by managers
- Supporting all staff in receiving Covid-19 vaccine and mask fit testing in a timely manner
- Support and information finding for a service with uncertainty about its future

9. How Concerns are Managed

Concerns are managed on a concern by concern basis, in line with the trust's FTSU policy. The FTSUG has regular 1-1's with the FTSU executive lead and CEO.

10. Training and Development for Guardians

The FTSU guardian is part of the regional and national network of guardians and prior to the first wave of Covid-19 regularly attended quarterly regional events, and annual national events. Although these are not meeting face to face, there is a fortnightly "teams" regional support meeting or workshop, with input from the national office.

11. Freedom To Speak Up, Raising Concerns Policy (Corp 69)

The current Freedom To Speak Up, Raising Concerns Policy was due for review and updating earlier this year. An updated policy was presented to the April Q&S committee and the May Board meeting.

12. Concerns Taken Directly to CQC

During quarter 4 one concern was taken directly to CQC. However, it was found to be identical to a previous concern raised with CQC and they were happy with the actions taken previously by the trust and reported this back to the person raising the concern.

13. The National Picture

For Quarter 4 this is contained in the annual report.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB095/21**	**FOI Exempt**	**NO**
Report Title	**FREEDOM TO SPEAK UP ANNUAL REPORT 2020 - 2021**		
Executive Lead	Bridget Lees, Executive Director of Nursing Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

To provide the Board with assurance that staff members are feeling able to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place to do so safely and confidently.

Executive Summary

The Freedom to Speak up Annual Report highlights the ongoing positive impact *Freedom to Speak Up, Raising Concerns,* is having across the organisation. Although the appointment of a Freedom to Speak up Guardian has had a significant impact there is no one route for concerns to be raised. It is hoped many concerns are easily resolved in local conversation with line managers and colleagues, and many of these will, quite rightly, never be heard about outside that forum. Some concerns are raised directly with the CEO, or other executive officers, and others directly through a HR process with union support.

Over the last year 83 concerns have been raised through the FTSU process.

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

Of course, the past year has been lived in the shadow of the Covid-19 pandemic. Nationally up to two thirds of Freedom to Speak Up Guardians were redeployed to other duties. Locally, although there was no formal redeployment, there have been significant challenges on time available. This may have led to there being less promotion of the FTSU service. However, the numbers show that concerns were still being raised and highlights the accuracy of the CQC statement following their visit and subsequent report of November 2019:

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

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

Recommendations

The Board is asked to **receive** the report and **note** progress made during 2019-2020 as well as to support future plans for 2020/21.

Previously Considered By:

Southport and Ormskirk Hospital NHS Trust

☐ **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:**
Martin Abrams, Freedom to Speak Up Guardian	Martin Abrams, Freedom to Speak Up Guardian

1. Introduction

The report provides assurance that people can raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place for staff to do this safely and confidently, knowing that appropriate action will be taken.

2. Freedom to Speak Up Annual Report 2020 – 2021

Over the last year 83 concerns were raised through the Freedom to Speak up Guardians or Champions. The concerns raised have been many and varied, some offering the opportunity for a quick fix, and others more complex in nature, and because of this time consuming.

A quarterly report is compiled after the data is submitted to the National Guardian's Office. The quarterly reports have highlighted issues raised, staff groups raising concerns and some of the areas of change that have resulted because of this. The quarterly report is presented to the Quality and Safety Committee and to the Trust Board and is also taken to the JNC Committee and Workforce Committee.

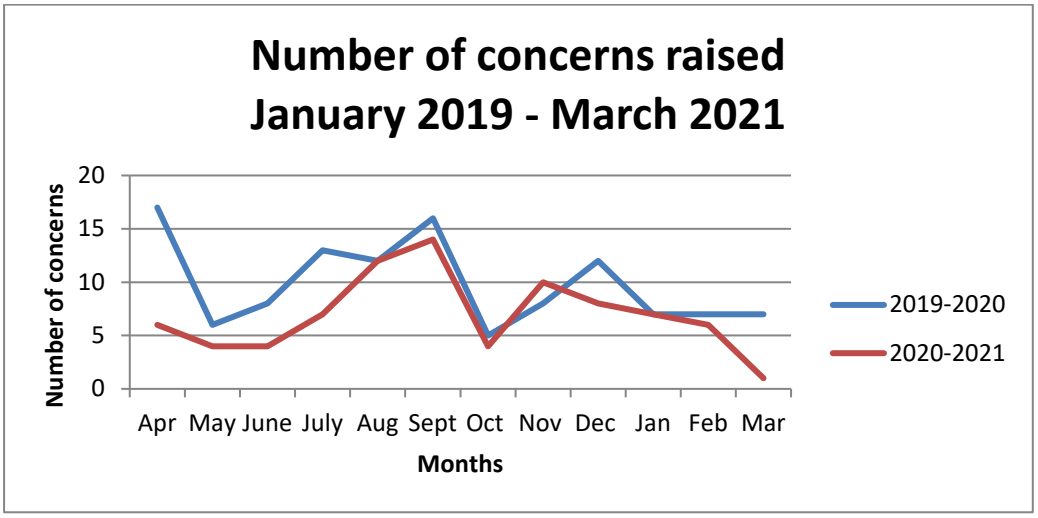
3. Overview of Concerns from the Year

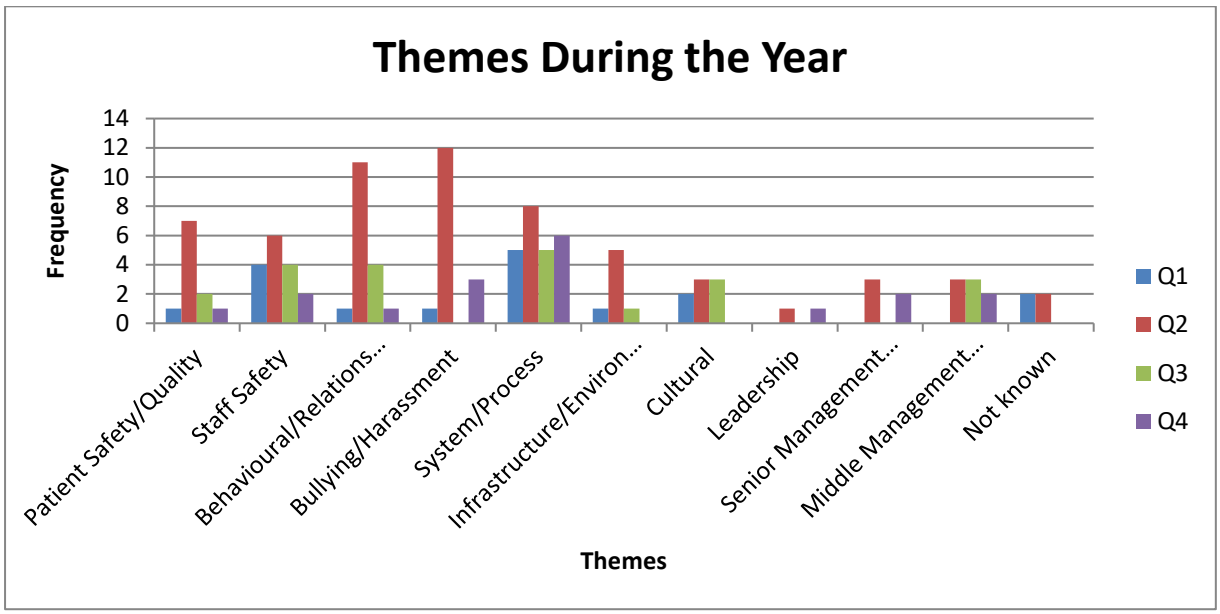
Concerns raised during the last year have included patient safety, staff wellbeing, concerns about department/environment, relationships, alleged bullying/harassment behaviours, equality act adherence, recruitment policy adherence, car parking, space for prayers, staff safety, sexual harassment, alleged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

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

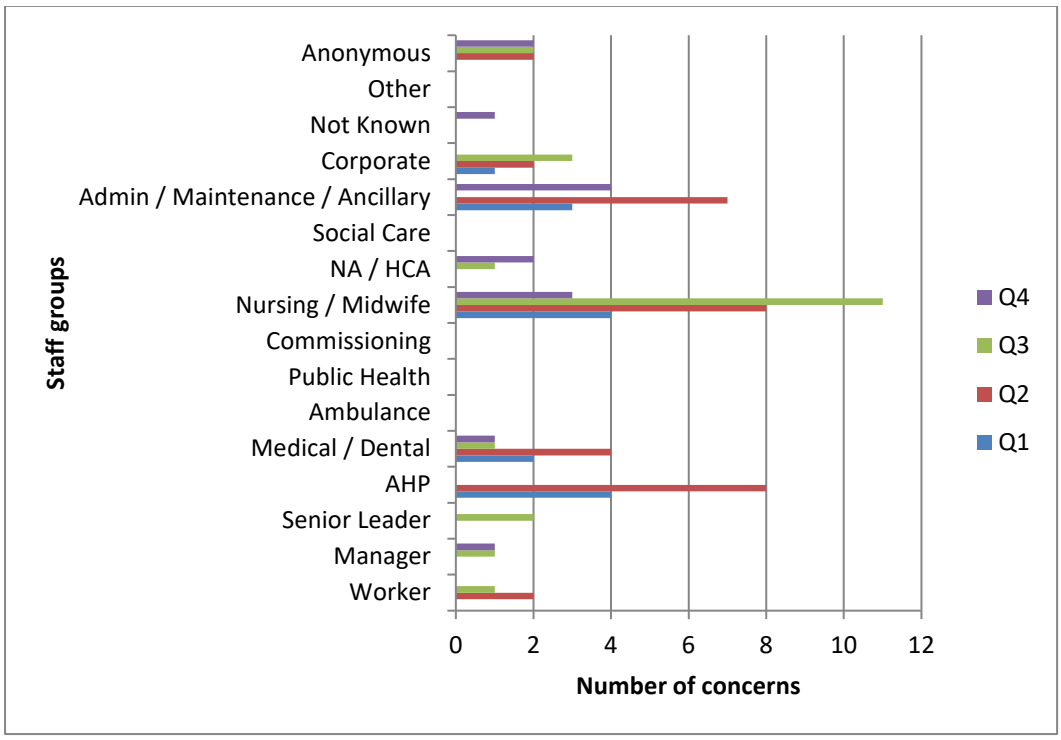
A selection of the tables, containing information about concerns raised during the year is below:

Please note the categories and staff groups are as defined by the National Guardian's Office.





Staff Groups Raising Concerns Over the Year



The above tables indicate the significant impact Freedom to Speak Up is having across the organisation. The reporting is proportionate with the highest number of concerns raised from nurses and midwives as the largest staff group.

4. Feedback from People Raising Concerns

Over the year feedback was received from 14 people. All of the feedback was positive, and they all said they would speak up again with the exception of one person who said they would not due to repercussions. A number of people commented the service provided as a *very good service* and *prompt.* They felt their concern was taken seriously and they were listened to leading them to feeling comfortable in raising concerns in the future. One person commented that as a result of raising their concern they now feel Covid-19 safe.

5. Ways Concerns are Looked Into

Concerns are considered in line with the Freedom to Speak Up raising concern policy, and resolution will be sought in various ways, ideally as locally and as quickly as possible.

6. Freedom to Speak Up Raising Concerns Policy

In the early part of 2021, the Raising Concerns Freedom to Speak Up policy was updated and is being presented to the Quality and Safety Committee and Trust Board for approval during the May/June cycle of 2021.

The Freedom to Speak Up Guardian holds regular meetings with the Chief Executive and other Executives and as well as talking about the formal concerns raised also discusses other issues in relation to the organisation, that have not necessarily been raised as concerns, but feature in conversations. This acts as “soft intelligence” for senior leaders within the organisation.

7. Concerns Raised Directly With CQC

Over the year four concerns have been raised directly with CQC. However, one of these (quarter 4) was found to be identical to a previous concern raised with CQC and they were happy with the actions taken previously by the trust and reported this back to the person raising the concern.

8. Staff Survey and Freedom to Speak Up Index

Both the staff survey and Freedom to Speak Up index have shown a slight improvement in relation to the organisation’s feeling about speaking up. Again, this is a very slow, but steady, improvement which we hope to continue over the coming years.

The following was reported in quarter 3:

- ☐ Each year the National Guardian’s Office produces an Index Report in relation to speaking up across the NHS with an indicator for each trust based on staff survey questions.
- ☐ The 2020 index indicates a local improvement (+1.6) within the index from 73% (2018) to 74.6% (2019). The index is based on the following four questions within the 2019 staff survey:
- ☐ % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- ☐ % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- ☐ % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- ☐ % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)
- ☐ Our improvement is in line with regional and national trends; however, it still leaves us below average (77.9 % for acute trusts). Speaking up is still being promoted and accessed within the

organisation, however Covid-19 has led to a temporary downscaling of plans for development. Improvement actions in relation to the four staff survey questions are incorporated into the Staff Survey Action Plan and specific work is being undertaken in relation to Organisational Development and culture.

This will also be incorporated into our CQC Well Led Improvement Plan and People Plan as the index suggests a positive speaking up culture is associated with higher-performing organisations as rated by the Care Quality Commission (CQC). In other words, trusts with higher index scores are more likely to be rated 'Good' or 'Outstanding' by the CQC.

9. Behaviours

A significant number of concerns raised still highlight that some of the behaviours of staff across the organisation cause concerns to others. A workstream is being developed to address the behaviours expected from employees. This programme to help improve this will be launched across the organisation soon and monitored by the 'Valuing our People' Group.

10. Training

Freedom to Speak up Training is now part of the Trust's mandatory training, divided into two sections. One section for all workers and one section for managers. As of 22 April 2021, across the Trust there is a 90.56% compliance with the training.

11. Champions

Unfortunately, due to the Covid-19 world pandemic, the recruitment and training of champions was put on hold during the last year.

Currently, we have 16 champions working across different parts of the organisation. Champions are sometimes approached within their locality for support or sought out as a first point of advice and play a valuable role within the accessibility of speaking up. We currently have a number of people who have expressed an interest and training is going to be arranged for June 2021.

12. Freedom to Speak Up Month

This year, due to Covid-19, Freedom to Speak Up month was scaled down. However, speaking up was highlighted within Trust News and social media and the guardian and champions were invited to have a conversation with the Chief Executive and Executive leads to speak particularly about the feelings of staff across the organisation.

13. **Publicity Across the Organisation**

FTSU uses many different media to highlight its role and availability to support people in speaking up. This includes posters, banners, computer screen savers, as well as *The Meeting Place, Twitter* and *Trust News*

14. Regional and National Support and Training

The FTSU guardian is part of the regional and national network of Guardians and prior to the first wave of Covid-19 regularly attended quarterly regional events, and annual national events. Although these are not meeting face to face, there is a fortnightly "teams" regional support meeting or workshop, with input from the National Guardian's Office.

It is always reassuring to be in touch with colleagues, both regionally and nationally, as many of the trends within our own hospital, are replicated with our regional and national colleagues. I have therefore included some information from the national picture and the annual report of the National Guardian's Office as part of our own annual report.

15. The National Picture

The National Guardian's Office Strategy 2021/2026.

The National Guardian's Office is currently looking to publish a 5-year strategy based on the experience of the last five years of speaking up. Further information will be published by the NGO during this current year but inevitably it will be building on the many achievements of the last five years and one of the likely consequences is training and qualifications for guardians to strengthen their working within organisations. More details will be published during the year.

The New National Guardian's Office Logo

During the last year a new logo has been introduced by the National Guardian's Office. The NGO offer the following reflection on this:

- *Since the formation of the office in 2016, the NGO has used the same logo and branded green. The decision to update our logo reflects the NGO's reach and remit expanding in the past four years. A network of over 500 Freedom to Speak Up Guardians have been appointed in all NHS trusts, as well as independent healthcare providers, national bodies and primary care organisations. Over 30 000 cases have been brought to Freedom to Speak Up Guardians.*

- *This new logo builds upon the recognisable green of the previous NGO logo, and communicates the flourishing of Freedom to Speak Up and the network of guardians.*
- *The term culture stems from the Latin 'cultivare', which means to cultivate and grow. We have chosen to use a tree in the new logo to symbolise that culture is deeply rooted in healthcare. The trunk represents the strong support network of Freedom to Speak Up Guardians. The 'leaves' symbolise the positive benefits of patient safety and worker well-being, when Freedom to Speak Up flourishes in a supportive environment; a culture where learning, sharing and speaking up are business as usual.*
- *For us, the tree also symbolises the guardian values: courage, impartiality, empathy and learning.*
- *Dr Henrietta Hughes OBE, National Guardian for the NHS, said, "I could not be prouder of the Freedom to Speak Up Guardians and everyone who has had the courage to speak up, particularly during COVID-19. Organisational culture can flourish when leaders listen and take action when people speak up."*

16. NGO Annual Report

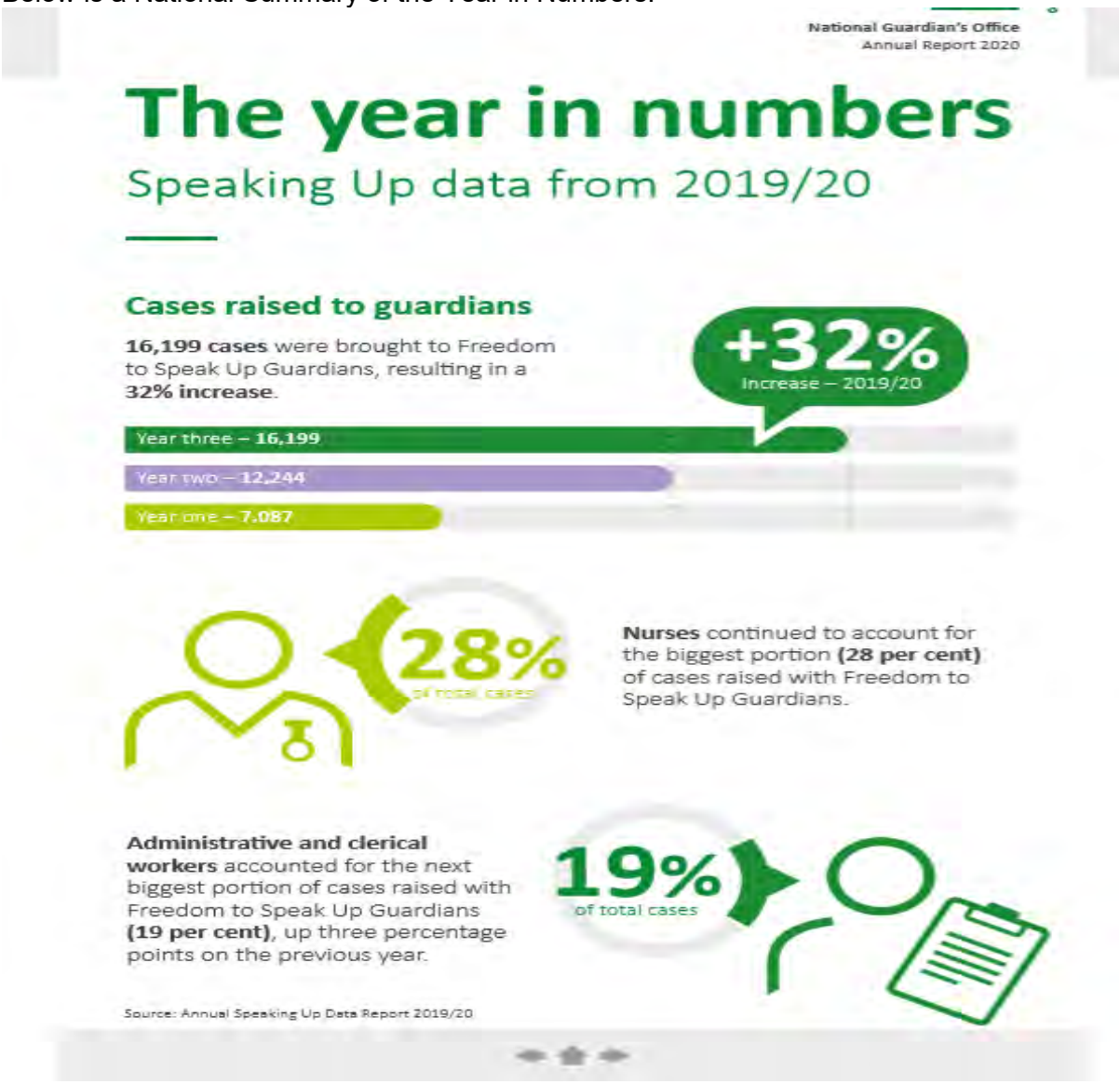
From the NGO Bulletin 18 March 2021:

- *The NGO today published its 2020 Annual Report. It highlights the progress and impact of Freedom to Speak Up, particularly during the pandemic.*

- *Henrietta said: "I am delighted to place our Annual Report before Parliament to illustrate the excellent work that Freedom to Speak Up Guardians have been doing, supporting workers to speak up throughout the pandemic and making a positive impact on the culture of their organisations."*

- *In his foreword to the report, the Secretary of State for Health and Social Care, the Rt Hon Matt Hancock MP, said: "I remain determined in my commitment to ensure that staff feel they can speak up and that their concerns will be taken seriously. I thank the National Guardian and the national network of Freedom to Speak Up Guardians, and every member of NHS staff who has spoken up, for helping to make our NHS safer."*

Below is a National Summary of the Year in Numbers:



The full report national report is contained in Appendix 1

National Guardian's Office
Annual Report 2020

Making **Freedom to Speak Up** business as usual.

CP 375

National Guardian's Office

Annual Report 2020

Presented to Parliament by the Secretary of State for Health and Social Care by Command of Her Majesty

March 2021
CP 375

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Contents

Ministerial Foreword

I am delighted that the National Guardian's Office has again seen such positive growth over the past year and to read of the excellent work that Freedom to Speak Up Guardians are delivering throughout England.

2020 was an extraordinarily difficult year for the NHS and its staff and the greatest test of NHS culture. In the darkest and most difficult times, it is more important than ever that everyone working in the NHS feels they can speak up, and that, when they do, they will be heard.

We should never forget what can happen when NHS workers struggle to speak up, or where organisations fail to listen. Tragedies like those at Gosport War Memorial or more recently the Independent Inquiry into circumstances around Ian Paterson have emphasised how important it is to embrace a learning culture in which we welcome speaking up and make it business as usual in the NHS.

Freedom to Speak Up Guardians are now well established in every trust in England, with increasing numbers in Clinical Commissioning Groups, regulators and NHS England and Improvement. They have handled over 35,000 cases over the last three years. But neither the National Guardian, nor I, are complacent. We know from last year's the Freedom to Speak Up Index report that there is more work to be done to ensure NHS staff feel confident they can raise their concerns.

That means excellent staff, managers and leaders who work together to develop a culture that welcomes speaking up, and where action is taken to address anything that gets in the way of providing great care. To speak up and be heard not only improves the quality and safety of patient care, but also, in tackling bullying and discrimination, the health of our vital NHS workforce.

I remain determined in my commitment to ensure that staff feel they can speak up and that their concerns will be taken seriously. I thank the National Guardian and the national network of Freedom to Speak Up Guardians, and every member of NHS staff who has spoken up, for helping to make our NHS safer.

Rt Hon Matt Hancock MP
Secretary of State
for Health and Social Care

Welcome from the **National Guardian**

Through our work we can now see clear evidence that a strong Freedom to Speak Up culture at all levels in healthcare has significant benefits. By creating a network of over 600 Freedom to Speak Up Guardians who have handled over 35,000 cases, those workers who might otherwise not have been heard have been supported to speak up.

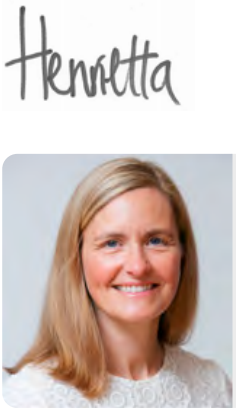
When leaders listen and act on speaking up, great improvements can be made. Conversely, when they are defensive or victimise workers who speak up, it has a chilling effect, putting patients and workers at risk of harm. Speaking up has never been more important than during the pandemic, and yet some workers who feared for their safety reported they were let down by leaders who were not listening.

The majority of cases refer to a problem or an issue where things are not working as well as they might. So, it's important that leaders both deal with the issue raised, but also apply the learning across the whole of their organisation. Only by taking action can they hope to truly embed the learning gained.

Over the next five years the pressures will increase in the healthcare sector. For the NHS to be able to deliver on the People Plan, leaders need to listen to the ideas and concerns from our colleagues. My annual report should act as a catalyst for change.

Workers need support and protection to speak up safely. Guardians need support and protection to deliver difficult messages. Managers need skills and headspace to be able to listen up effectively. And senior leaders need to listen, believe and take the necessary actions, fostering a positive speaking up culture.

Speaking up is a gift – use it wisely and we can change the NHS for the better.



Dr Henrietta Hughes OBE FRCGP
National Guardian for the NHS

Speaking up – the journey so far

Five years have passed since the publication of the Francis Freedom to Speak Up Review in 2015. The speaking up culture of the health sector in England has changed with a network of over 600 Freedom to Speak Up Guardians in over 400 organisations.

There is still much more to do and we will build on the learning from the past five years to support further improvements.

This will require all organisations to play their part.

We have made more than 100 recommendations from case reviews. It is time that these are adopted and embedded to prevent the national scandals which are still happening, where, had the voices of workers not been suppressed or victimised, patient safety could have been improved.

From our case reviews significant themes have emerged and we will be focusing our efforts on the voices of vulnerable workers and the barriers they face to speaking up.

We have launched, with Health Education England, training for all workers, and plan training for managers and leaders – everyone needs to take personal responsibility for their actions.

Principles from the Freedom to Speak Up Review are not being followed by all organisations. Regulators are mobilising and taking this more seriously but there is more to do to get a consistent and aligned response to speaking up. This matters to keep patients safe.

As the health landscape continues to evolve with the development of integrated care systems (ICS), speaking up needs to be at the heart of this transformation. We are working with primary care organisations to show how this can work at system level.

By working in partnership with others we will improve speaking up across patient pathways.

The National Guardian's Office

While the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, our broader strategy is to effect cultural change. That is to contribute to our National Health Service leading the way in embedding a 'learn, not blame' culture that seeks to change and improve.

Speaking up is a key part of that strategy as workers have information and precious knowledge about the way in which our health service operates that cannot be garnered from anywhere else. Supporting NHS workers to speak up, listening to what they say and acting upon that information to improve encapsulates what the National Guardian's Office is trying to achieve.

Any organisation can appoint a guardian. Organisations that provide services under the NHS Standard Contract (which includes but is not limited to NHS trusts and Foundation Trusts) are required to nominate a Freedom to Speak Up Guardian.

NHS primary care provider organisations are expected to follow NHS England's guidance on Freedom to Speak Up.

In addition, the National Guardian's Office expects health and care leadership organisations and regulators to appoint guardians, and are encouraging an increasing number of non-health organisations that are also appointing guardians.

Individual organisations decide who is best placed to take on the guardian role and some organisations choose to appoint more than one guardian. Guardians need to be able to carry out all aspects of the 'Universal Job Description' developed by the National Guardian's Office and should be able to inspire the trust and confidence of workers and senior leaders.

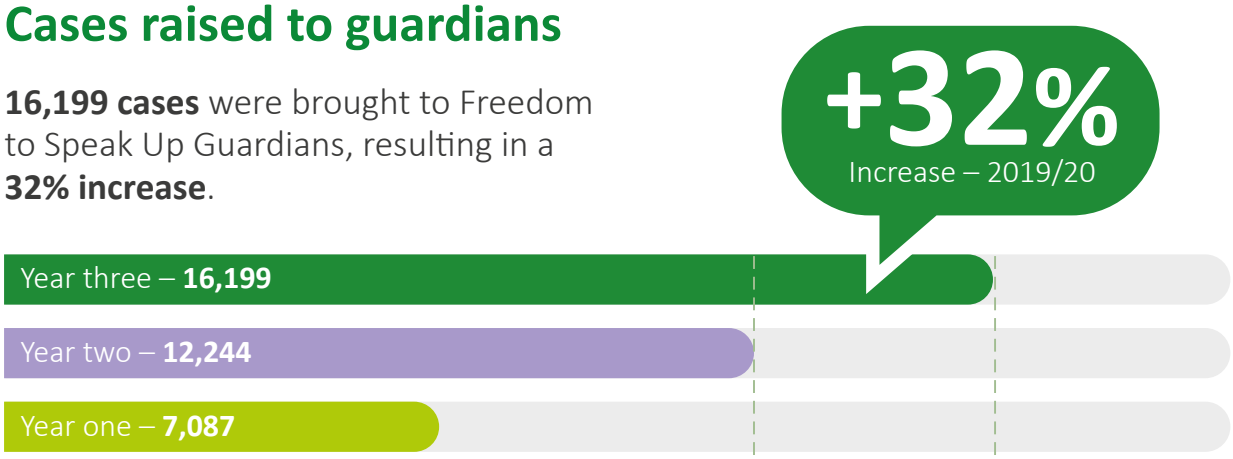
The office leads, trains and supports this network of Freedom to Speak Up Guardians in England. We produce guidance documents relating to areas such as recording cases and reporting data and CQC inspections.

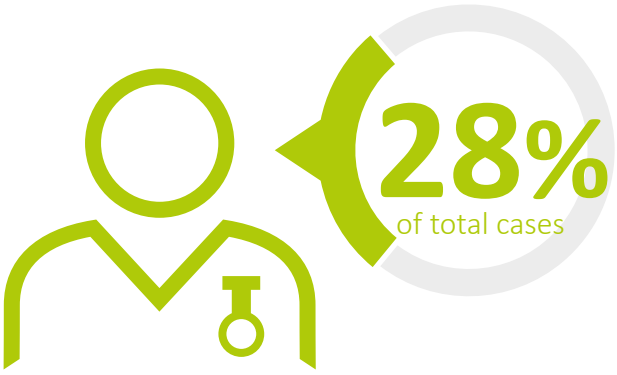
The year in numbers

Speaking Up data from 2019/20

Cases raised to guardians

16,199 cases were brought to Freedom to Speak Up Guardians, resulting in a **32% increase**.





Nurses continued to account for the biggest portion **(28 per cent)** of cases raised with Freedom to Speak Up Guardians.

Administrative and clerical workers accounted for the next biggest portion of cases raised with Freedom to Speak Up Guardians **(19 per cent)**, up three percentage points on the previous year.

Source: Annual Speaking Up Data Report 2019/20

Guardians and the network

There are now **612** guardians in over **400** organisations.

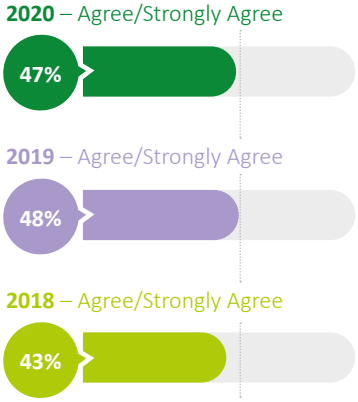
Trusts

Other providers (all other providers of healthcare, e.g. independent and primary care)

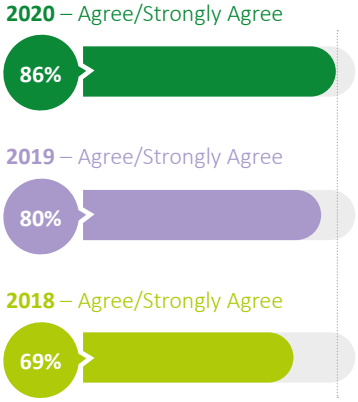
Other bodies (all other bodies with guardians, e.g. Clinical Commissioning Groups, Care Quality Commission, NHS England/Improvement)

Perspectives of Freedom to Speak Up Guardians

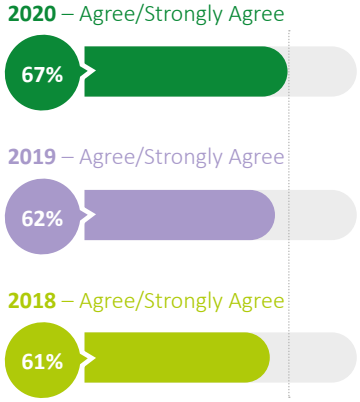
Believe people in organisation **do not suffer detriment** as a result of speaking up.



Believe Freedom to Speak Up Guardian role **is making a difference.**



Believe organisation has a **positive culture** of speaking up.



Source: Freedom to Speak Up Guardian Survey 2020

You said, we did: an International Medical Doctor's experience

University Hospitals Dorset NHS Foundation Trust

An international medical doctor (IMG) came to Helen Martin, Freedom to Speak Up Guardian at University Hospital Dorset, deeply distressed.

"She was both isolated and unsupported," said Helen. "She had just moved from India into a speciality registrar post, leaving her family to learn more from our National Health Service and take back the benefits for her patients. She was a lead in her medical field in India.

"Whilst she was exceptionally competent at medicine, her inexperience of how the NHS functions – the countless abbreviations and the secret idiosyncrasies we have – were making her transition very difficult. Her relationships with her team were becoming strained and busy workloads made conversations difficult and behaviours unsupportive.

"Without knowledge of how the system works, I found myself helpless and low in confidence," said the doctor. "This led to low self-esteem which affected my sleep, my emotional and physical stability. My mind was blocked from fear."

Helen suggested she talk to her educational supervisor and write a statement about the behaviours from one particular doctor, which were investigated and resulted in a facilitated conversation.

"When we first met, she wanted to leave and go home but the strength she got from speaking up and calling out this behaviour made her complete her full placement and even stay longer to support the first wave of COVID-19," said Helen.

The International Medical Doctor was happy to share her experience of speaking up with others and filmed a short "you said, we did" video which Helen used to share a staff story at Trust board and used throughout the trust to encourage others to speak up.

Helen also shared the doctor's experience with the medical educational lead to better understand how the international medical workforce was supported. An International Doctors Support Initiative (IDSI) programme was just being put into place and consisted of five key elements including induction, integration and wellbeing forum, teaching programme and career development.

The Freedom to Speak Up team attended this forum to listen to IMGs discuss and raise concerns about various issues including contracts, bullying and discrimination. With the support of the FTSU team, the IMGs' confidence of their medical ability and career choices as well as their health and wellbeing have been restored and loneliness and isolation has been reduced.

One of the IMGs said, "When I was going through a bad time, somebody from the Freedom to Speak Up Guardians checked on me every week and even offered to take me for walks, which made me feel that I have someone to look out for me".

As a result of one person speaking up, a forum has been established to mitigate feelings of culture shock and social isolation by the international workforce and helped to promote a culture of speaking up.

Helen Martin
Freedom to Speak Up Guardian

Thinking outside the box:
Listening up in a different way

Leeds Community Healthcare NHS Trust

John Walsh, Freedom to Speak Up Guardian at Leeds Community Healthcare, was asked by the Director of Nursing to be part of an away day for a team that was having serious difficulties.

When the day started, staff started to speak up about issues and concerns. They also spoke up about away days. "They said they had seen it all before – people coming in who they never see again, post-its are put on walls and there is a lot of talking but nothing really changes," said John.

"This really touched me and I found myself offering to visit the team for a half day once a week for six months to listen, support and raise whatever they wanted to say in an impartial way. Normally I would have simply asked them to contact me as the Freedom to Speak Up Guardian."

The workers accepted John's offer and every week he visited and listened to the workers. "I was humbled to see the great care and compassion the staff had for those who used the service. I met some wonderful people delivering good healthcare in difficult circumstances. I would raise their concerns, struggles and creative ideas for improvement with Director of Nursing and managers.

One day, I happened to see a poster the trust had created based on this work. It didn't say 'You said, We did' but rather 'What We have Done Together'. I recognised the matters as suggestions and issues raised by the team from my weekly emails sent to the Director of Nursing and managers. The poster listed issues, actions and timescales."

As time went on, the concerns got less and less and that service moved to a much better and stronger place.

"This example shows a lesson all organisations need to remember – that the wisdom, expertise and experience within teams and services is where we need to start," said John. "I have also learnt there is rich work outside my usual practice box and this will link us to how Freedom to Speak Up can flow deeply into our organisations for care and culture change."

John Walsh
Freedom to Speak Up Guardian

Data and **intelligence**

One of the key areas that the National Guardian's Office has focused on this year is becoming a more intelligence driven organisation that takes strategic decisions based upon what it can recognise taking place across the system.

By using data to improve our understanding of the speaking up landscape, we are better able to support improvements in the way speaking up takes place across the whole of healthcare.

One way in which we track the progress of healthcare providers to embed speaking up is by looking at the number of cases raised to Freedom to Speak Up Guardians. The quarterly data we collect from organisations with guardians allows us to recognise themes and provide challenge back.

When there have been no cases reported, we liaise with NHS England/Improvement (NHSE/I) and feed into their broader understanding of what issues may account for this.

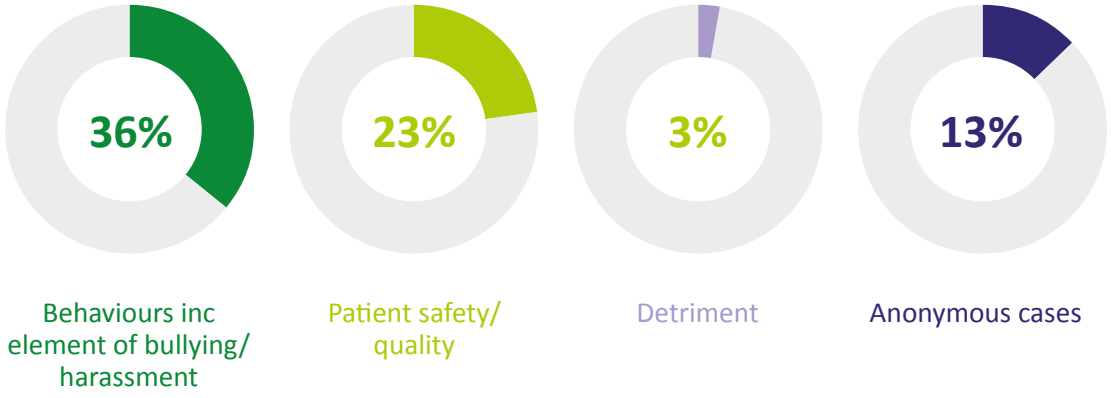
Over the last two years we have also published our Freedom to Speak Up Index Report that draws on answers provided in the NHS Staff Survey relating to speaking up.

We also conduct an annual survey of guardians and that has allowed us to recognise areas we can focus on going forward, including the level of support we offer to guardians, how guardians support each other, and how we can improve our understanding of the impact of the guardian role. These have been outlined in a report published on our website titled, 'Next Steps: Priorities 2020-2021'.

Information gleaned from our survey is also contributing to planned workstreams relating to detriment, vulnerable groups and other barriers to speaking up. Anecdotal information from the survey, when viewed alongside speaking up data – for example with regards to anonymity and detriment – is helping us to develop a fuller picture of how to overcome barriers to speaking up.

We are also working with NHSE/I and other stakeholders on the development of a common data set from a range of sources, including through the NHS Staff Survey, to improve how they capture views on understanding of speaking up culture and arrangements.

Cases brought to Freedom to Speak Up Guardians 2019-2020



Results from our Annual Data Report 2019-20

The other significant area of our work that allows us to make some really deep dives into data and intelligence is our case review process. Where referrals are made to the office about incidents of speaking up where matters may not have been handled in line with best practice, we are able to look in detail to understand what learning can be gained.

All healthcare providers are encouraged to review our recommendations and check whether they can learn from them and make changes.

We now plan to take that a step further and use data more intelligently in the case review process in order to hear the voices of more workers.

One of the most notable changes we have made this year is the inclusion of information on speaking up as part of the NHS E/I Model Hospital digital information service. There is more about our work in this area on page 16 of this report.

A Junior Doctor's experience leads to cultural change

A Large Midlands Acute Trust

A male Foundation Year One doctor from a BAME background made contact with the Trust Freedom to Speak Up Guardian exploring several routes to express their concerns of incivility and discrimination in the workplace.

He spoke about his experience, telling the Freedom to Speak Up Guardian, **"I felt that my ethnic background and gender meant I was criticised more harshly than the others and so I was hesitant to express my fears. I began to distrust the people I worked with.**

"On social media gossip was rife…very quickly I was singled out as I did not participate. I was labelled as quiet and careless and would often be undermined in front of other staff."

When the Junior Doctor witnessed another doctor of BAME background who had just joined the department from a foreign country being bullied by the same people who had treated them badly, they spoke with several other doctors including a registrar, who were very supportive but were not able to help.

"It was only when I contacted the guardian, that I felt like someone was actually listening," said the Junior Doctor. **"I finally thought that something could be done to ensure no one else felt the way I felt."**

The Junior Doctor did not want to make a formal complaint but was encouraged by the guardian to share their experiences with the Deputy Medical Director, who listened and wanted to ensure that as an organisation something was done. It was agreed that a video would be created about the experiences of an FY1 and how Freedom to Speak Up can help support workers who wish to raise concerns.

The Trust's Medical Director said, **"I found the account of the Junior Doctor very distressing and I am sure this is not an isolated incident in the organisation. There is no place for discrimination of this nature within the organisation. We want this to be an organisation where everyone is absolutely valued for the richness they bring to the organisation and the contribution they make."**

The trust guardian said, **"The aim of the video will be to bring some positive cultural change with how we treat one another. The organisation have wanted to learn from the experiences of the FY1 and take a learn not blame approach.**

"I would like to encourage all FY1s to raise their concerns and speak up if they experience poor attitudes and behaviours in the workplace," concluded the Junior Doctor. **"Contacting the Freedom to Speak Up Guardian made me realise that I was not alone, I was listened to and I was supported to speak up."**

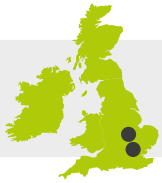
These concerns were raised during the height of the first wave of the COVID-19 pandemic. The impact of the disease on BAME workers, the Black Lives Matter protests and death of George Floyd meant that there were heightened emotions about these issues.

All staff received a CEO statement, one that was honest and shared empathy with workers. Listening events took place with the CEO through the BAME Employee voice group, and a Trust Board Development session further held. The Junior Doctor's story was shared along with concerns which had been raised by workers about diversity and inclusion.

In addition, the Trust has appointed to the role of Head of Equality, Diversity & Inclusion to work towards further embedding EDI measures and interventions.

The video will first be shared with the Trust Board as part of the FTSU Guardian's board report and then as a training resource to the Junior Doctors Forum, Consultant Committees and more widely used within the FTSU training the guardian delivers at the Trust in ensuring cultural change. The Trust takes discrimination in the workplace very seriously and is ensuring every effort is made to stamp this out.

A Patient Safety Issue:
Recording Allergies



Cambridgeshire and Peterborough NHS Foundation Trust

"I spoke up not because any one person was doing wrong, but because the system wasn't being utilised properly and it could lead to a serious patient safety incident," says Hannah Cox.

I had been with CPFT for just over a month and I was still getting to grips with all the different aspects of my role in a busy service for older people. I found myself checking patient summaries to make sure that the patients' allergies had been checked before medication was requested for prescription.

The problem was that allergies were not being recorded on the front page of the patient's electronic record, even when there is a clear icon to indicate if that person has allergies.

There was no standardised process for where allergies should be recorded and being new to the Trust and system meant it was extra difficult for me to check.

There had been a couple of close calls. I'd asked my line manager if they should complete a DATIX as it had the potential to become a serious incident. My line manager said it was a confusing issue that had been going on for some time. Because so many people did it, it felt hard to challenge people on their habits.

I contacted Annie, the Trust's Freedom to Speak Up Guardian. She thanked me for bringing the issue to her attention. I was happy for Annie to share the concerns I'd raised with relevant colleagues. The Clinical Director contacted me straight away. He was very kind in explaining the steps he was taking to standardise the allergy recording process and I appreciated how professional and understanding he was.

My experience has really brought home how Freedom to Speak Up has developed a collaborative environment at CPFT that can solve issues effectively. Our team really listened and thanks to Annie's help and clinicians learning how to input allergies into the system's allergy database, it is no longer an issue. Now when I access patient records, we can easily see the icon highlighting the patient's allergies on the clinical system.

Hannah Cox

Annie Ng
Freedom to Speak Up Guardian

Improving the system

Part of the National Guardian's remit is to provide challenge and learning to the healthcare system in order to effect cultural change. We work together with our stakeholders to provide practical tools to help support the system to make speaking up business as usual.

We are working with colleagues at NHS England and Improvement (NHSE/I), with input from Freedom to Speak Up Guardians, on the development of the culture and engagement compartment on the Model Hospital database.

The Model Hospital is an NHS digital information service designed to help the NHS improve productivity and efficiency. The compartment the National Guardian's Office has contributed to contains a range of speaking up indicators, including data from guardians in NHS trusts on the speaking up cases raised with them.

NHS trusts, including guardians in those organisations, as well as others in the health system, are able to use the culture and engagement compartment on the Model Hospital to compare metrics and identify areas for improvement.

The National Guardian's Office and the Model Hospital team have held webinars and included information in our fortnightly bulletin for guardians to help guardians understand how they can use the Model Hospital to learn and improve.

The CQC is a key partner in helping to underline the importance of good speaking up practices and the role of the guardian. We are working with them on rating characteristics, so that speaking up is properly reflected, as well as speaking up getting proper consideration at the point of registration.

We have also worked with colleagues at the CQC to update our guidance, `CQC inspections: Information for Freedom to Speak Up Guardians' and we are working with the CQC to deliver training about speaking up to hospital inspectors.

Making Speaking Up business as usual

While there are challenges that the National Guardian's Office faces in embedding speaking up across the NHS, there is also a prevailing wind that has both helped and informed the work of the office and the organisations it works with.

Speaking up has become as much a social movement as an NHS initiative. Over recent years, whether in relation to Black Lives Matter or the #MeToo movement, it has become apparent that people feel they deserve the right to speak up and expect to be listened to.

The National Guardian's Office often describes speaking up as 'a gift'. The information that workers can provide should be seen as vital to the wellbeing of the organisation and as a means to change and improve in order to address the issues being raised.

There is also an expectation from workers that their voice should be one of the driving forces in informing change and improvement. The NHS Staff Survey gives workers a voice and the impetus to use that to make things better is implicit.

We can learn much from other sectors and have established a flourishing Pan Sector Network. With a growing membership of over 50 organisations, the network shares learning from diverse sectors including the police, aviation, the arts, the charity sector, financial services, defence, telecoms and retail.

The network shares challenges and perspectives on how to encourage a speak up culture. We in turn share this learning in our regular newsletters to stakeholders throughout health, so that we might learn from the good practice of others.

A Health Visitor's concerns lead to learning and improvement

Hounslow and Richmond Community Healthcare NHS Trust

A member of the Health Visiting team contacted Graham Rodber, the Freedom to Speak Up Guardian at Hounslow and Richmond Community Healthcare Trust, about their team structure. They were concerned about operational decision making and management of risk and that a high volume of agency and bank staff were working within the team.

Permanent part-time staff were not able to take on additional hours to cover shifts that were vacant and the concerns centred around longer-term agency and bank staff not having appropriate induction, supervision or training. Further concerns regarding the flat structure and lack of senior leaders within the team were also raised.

Graham contacted the Director of Nursing and Non-Medical Professionals who is the responsible director for Freedom to Speak Up within the organisation. An external investigation was commissioned. The worker who raised concerns was supported throughout the process and Graham kept them informed on the investigation's progress.

As a result of the external investigation, a series of recommendations were made including an urgent review of all existing agency staff and their compliance with training, performance issues, supervision and knowledge of the clinical computer system – SystmOne. Further recommendations were to ensure that references are requested from agencies for all future agency recruitment and to prepare an audit of supervision themes for the safeguarding committee.

In addition, it was recommended that the learning from the outcomes of the investigation should be shared with Health Visitor Teams via a learning event using an Appreciative Inquiry approach.

Appreciative Inquiry is a way of looking at organisational change which focuses on identifying and doing more of what is already working, to identify and spread good practice.

Following the conclusion of the investigation, Graham said, **"The worker was absolutely right to raise their concerns with me, and I am glad we were able to support them throughout the process. Other workers within the Health Visiting teams will have seen that concerns and feedback are taken seriously, and the organisation acts upon matters raised. I hope that all workers will now feel confident and safe to raise further matters should they arise in the future".**

Graham Rodber
Freedom to Speak Up Guardian

Speaking Up creates a happier workplace

SELDOC Healthcare
Integrated Urgent Care Provider, SE and SW London

SELDOC – the South East London Doctors' Co-operative – provides urgent and unscheduled care services in South London. In addition to providing out-of-hours care to seven CCG areas, SELDOC supports A+E Departments, GP federations and the London Ambulance Service.

An anonymous worker raised concerns over the introduction of advanced clinical practitioners where traditionally the service had only used GPs in its clinical workforce. The worker also questioned operational procedures, and cited examples of poor management.

SELDOC CEO, Steven Pink, commissioned an independent investigation which made a series of recommendations.

One was to have a Freedom to Speak Up Guardian as an alternative route for workers to speak up.

The introduction of a Freedom to Speak Up policy and the presence of a guardian external to the organisation from Howbeck Healthcare, created a more formal structure for raising matters, which promoted greater transparency within the organisation. SELDOC also introduced an internal Freedom to Speak Up champion who workers could turn to if they didn't feel able to contact their supervisor or manager.

There is also a dedicated email address for workers to contact Steven, the CEO, directly and confidentially. This has been used and valued by staff. "One team member trusted me enough to chat directly about her maternity leave concerns, which we were able to resolve immediately," said Steven.

He continued: "Ultimately, the process has given us an opportunity to show both employees and customers that they shouldn't be afraid to say what they want. Some people are more comfortable speaking up than others, so it's important we continue to encourage people to speak up using one of the now multiple points of contact."

The investigation process uncovered feelings around acceptable management behaviour, which led to an acceleration of a pre-planned culture of change.

> "You can never over-communicate about changes you're making and why," said Steven. "We now have weekly calls with office staff, managers, routine drivers, receptionists… things that were happening once a quarter are now weekly. I also conduct monthly calls in which anyone can join and ask me anything."

These interventions have made a difference. In recent internal staff surveys, scores show SELDOC as a welcoming and inclusive organisation.

"The investigation process was a wake-up call for the organisation," concluded Steven. "Nobody wants a whistleblower scenario, particularly in healthcare. But far worse is that 'stuff stays buried'. We want our staff and colleagues to know they have someone they can turn to at any time. We will always encourage them reach out in order and share concerns so that we can action them appropriately and quickly, with a clear focus on what is best for our patients."

Steven Pink
SELDOC CEO

Embedding the learning

One of the core guardian values is learning, so it is critical to our work that we share learning across the network of guardians and beyond.

Our primary channel for sharing information and learning with the guardian network is through our fortnightly bulletin. This provides a vital means of engaging guardians with the latest news, information and guidance they need to do their jobs in the best possible way.

We also host a monthly webinar series that we have found increasingly popular. Here we can discuss a range of topics such as how to engage with specific groups such as trainees to how to use data to provide Boards with insight and understanding. We now also record our webinars so that those guardians unable to make the webinar session can catch up.

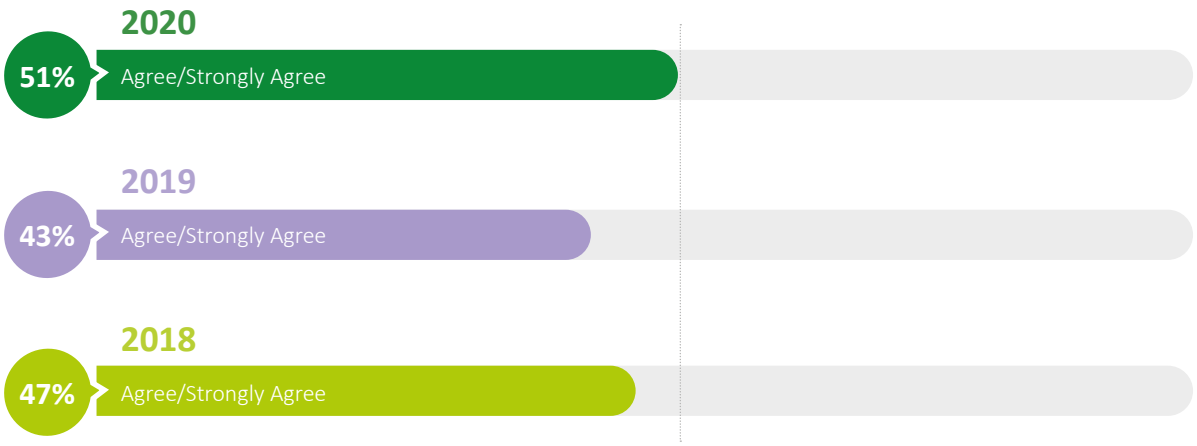
Our Speak Up Month campaign held throughout October every year has also augmented how we spread learning throughout our network and beyond. Guardians from all over England use the month to share what they do to support speaking up in their organisations. This year we devised an Alphabet of Speak Up to encourage contributions from stakeholders across health to share what speaking up meant to them. Over 650 different words were suggested as part of the #SpeakUpABC and the hashtag was used 8,219 times.

A further thread that brings to the fore the very best work of guardians is the Health Service Journal (HSJ) Award we sponsor. In 2019 the Freedom to Speak Up Organisation of the Year Award was won by Rotherham, Doncaster and South Humber NHS Foundation Trust for 'developing compassionate speak up cultures within and across systems'.

600 people registered to attend **8 Lunch** and **Learn** webinars

767 have **'watched again'** on **YouTube**

Managers support staff to speak up



Freedom to Speak Up Guardian Survey 2020

Recognising and rewarding the efforts of guardians and their organisations to change the culture of the NHS by elevating the importance of speaking up is a key part of our role as the National Guardian's Office.

One of the ways we share learning, and encourage peer support is through network meetings. These bring groups of guardians together on a regular basis, mostly by region, but we also have national networks for ambulance trusts, hospices and non-providers. Together guardians are able to provide support and learning to one another, while also getting updates from the national office as well as taking advantage of the chance to feedback.

More specific advice can be requested through one-to-one guardian surgeries that can be booked with the NGO when guardians have particularly tricky cases they are handling.

Learning is also shared through features detailed elsewhere in this report, such as our training, our case review recommendations and through conferences and events we organise. The latter not only brings together keynote speakers that have included Ministers and senior health officers, but also allows excellent networking opportunities and workshops.

Dr Navina Evans CBE

Chief Executive, Health Education England

As Chief Executive at Health Education England (HEE), I am delighted that we have recently launched our network of Freedom to Speak Up Guardians. This is part of our commitment as an organisation to addressing barriers, raising concerns, and continual learning and improvement.

For me personally as a leader, Freedom to Speak Up is vital not only in ensuring that staff feel safe to speak up about issues affecting them, but also so that I can be made aware of some of the general themes coming out of those conversations that may reflect the need for greater organisation-wide changes.

HEE's FTSU Guardians are supported by the National Guardian's Office, with access to training, support and other resources that enable them to offer support to staff throughout the organisation.

We have also worked with the National Guardian's Office to develop 'Freedom to Speak Up' – a learning resource aimed at all NHS colleagues including volunteers, students and those in training, regardless of their contract terms.

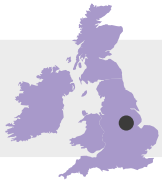
While the aim will always be to create an organisational culture in which workers do not need FTSU Guardians to speak up, we recognise that there will nonetheless be instances in which they prefer to speak up confidentially. Creating a safe environment where workers can raise comments, concerns and feel listened to ensures they feel comfortable at work, and ultimately results in the delivery of high quality care for those that we serve – the people of England.

Senior leaders **support staff** to speak up

Freedom to Speak Up Guardian Survey 2020

Dr Navina Evans
Chief Executive,
Health Education England

Angela Hillery



Chief Executive, Northamptonshire Healthcare NHS Foundation Trust

Freedom to Speak Up means we are placing safety first as an essential part of our culture and creating the conditions needed to deliver high quality care. It provides a way for our front line workers to speak up if they have any worries or concerns about the care they provide or see.

As a leader at NHFT, with over 4,000 staff, I need to know that everyone has a way of speaking up, whether it is a big or small concern, and what their experience is. Every piece of information is invaluable, and it encourages everyone to be a leader, to prioritise safety and to collectively improve care for our patients and improve our staff experiences.

Freedom to Speak Up has enabled us to triangulate data and information, to have early sight of issues and to understand what we need to improve upon. I have been made aware of information that may have not been visible to me, enabling me to explore it further and act. As time has progressed it has become part of what we do here at NHFT – "Let's Talk" is how we frame it to make it simple and to signal that everyone can contribute.

We have developed FTSU Champions in the Trust who support our FTSU Guardian, and this has really helped us to extend the reach and access to our workers, particularly those who are more vulnerable including students, junior doctors and people with protected characteristics.

Our FTSU Guardian pro-actively promotes the role and has developed many materials to support people. He is highly visible which builds confidence and trust within our organisation and people know who to go to if they need to. He actively listens and recognises how people can feel when they raise concerns by quickly providing reassurance to them. This is so important in nurturing a culture of speaking up, quality improvement and learning. He can access all people and parts of the Trust and will take forward any issue or concern, challenging where this is needed and confirming that action is being taken. He also provides feedback to anyone who has spoken up which I believe is key, so they know what and how the guardian has acted on their behalf.

The NGO provides resources and information including learning from other organisations. We review all this information to ensure that any external experiences can be considered in our Trust too. The NGO also provides information, training and support for our guardian who networks with others on a regional and national basis and obtains invaluable peer support.

My advice to all leaders is that you need a speaking up culture to ensure `safety first' is recognised as a priority within your organisation. As a leader you need to value speaking up and recognise it as a key feature of any high-quality culture. It will help you to provide and promote continuous quality improvement as well as the importance of being a learning organisation.

Angela Hillery
Chief Executive,
Northamptonshire Healthcare
NHS Foundation Trust

The future is now

Having looked back at the activities that have defined the National Guardian's Office in 2020, it feels important that this year – perhaps more than any other – we should reflect on the coming 12 months.

COVID-19 has hung heavy over everything happening in the country, but particularly in healthcare where it has affected the lives of all workers. At the start of the first lockdown we launched three pulse surveys to gauge the impact of the pandemic on speaking up.

Feedback from guardians who responded was mixed. Some told us that an established culture of speaking up made things easier. Others reported they were told there simply wasn't time to listen to everything workers were raising. There were also anecdotal reports of communications teams advising workers not to speak to the media or use their social media to post comments. With the CQC Chief Inspectors, the National Guardian wrote to all trust CEOs and Chairs to remind them about how important it was to maintain safe speaking up channels for their workers.

We repeated the pulse surveys in May and again in June, and a change in attitudes and perceptions evolved as the pandemic continued. In the first pulse survey, 72 per cent of guardians who responded believed that workers continued to be encouraged to speak up. By June that had risen to 93 per cent.

This was reflected in the feedback guardians provided about whether speaking up was decreasing or increasing. In April there was roughly a 40/40/20 split with 40 per cent saying speaking up was decreasing, 39 per cent saying there was no change and 21 per cent saying speaking up had increased.

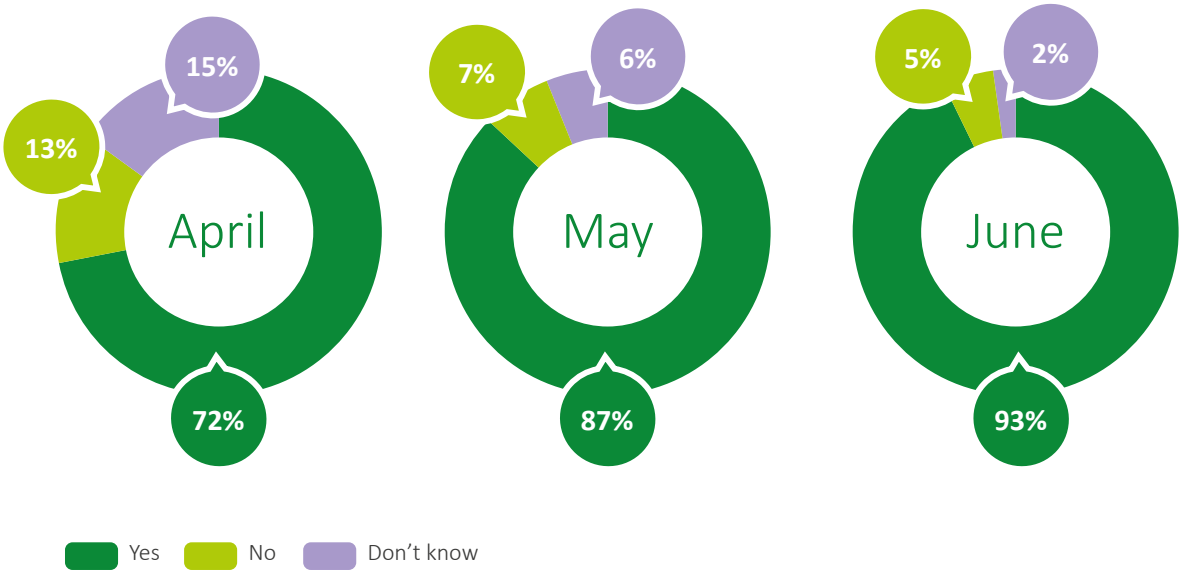
By June, however, just over half said speaking up was increasing. The percentage of those saying it was decreasing dropped by more than half to 17 per cent, with the remaining third saying there was no change.

The types of issues workers were speaking up about showed a significant increase across the three months when it came to behavioural issues, such as bullying and harassment. This rose from 46 per cent in April, to 57 per cent in May and up to 74 per cent in June.

We contributed our findings to the NHS Reset campaign being championed by NHS Confederation and also fed the results into NHS England/ Improvement and the Workforce Race Equality Standard Team. COVID-19 will surely impact further on the lives of healthcare workers and what guardians have brought to them as the vaccine rolls out and beyond.

Our work making in-roads into primary care has also taken significant steps forward and will continue to emerge over the next 12 months. Regional Integration Plans have been produced to describe our actions going forward and how we can measure progress and uptake.

Are workers being encouraged to speak up during the COVID-19 pandemic?



Results from our Pulse Surveys run during the first wave of the pandemic.

We have worked closely with stakeholders, such as our Partnership Working Group, to ensure we capture the system learning extracted so far from our work in primary care. As we look to the future we are reassessing our approach both in terms of our own resources and capacity, but also in relation to our work with guardians.

The future of the guardian role is being shaped by new approaches to training, the way in which networks will be managed differently, a more diverse constituency and seeking to gain greater assurance through our systems and processes.

In 2020, we launched Speak Up, the first module in our e-learning package, developed in association with Health Education England, for all workers, so that they might have the tools to speak up. A second module for managers – Listen Up – launched in January 2021. The final e-learning module – Follow Up – developed for senior leaders – will be launched later in the year.

Governance

The National Guardian's Office (NGO) is funded by the Care Quality Commission (CQC), NHS England/Improvement. Senior representatives from the CQC and NHS Improvement form the office's Accountability and Liaison Board (ALB).

Current ALB members are:

Sir Robert Francis QC
CQC Non-Executive Director

Sir Andrew Morris, OBE, Hon FRCP
NHSI Non-Executive Director

The ALB meets four times a year. Its responsibilities include:

- Acting as a 'critical friend' for the office, providing input and guidance on strategic plans and development
- Acting as key liaison point between the NGO and its funding bodies
- Reviewing complaints made about the office

This report is laid before Parliament and the National Guardian for the NHS reports annually to the boards of CQC, NHS England/Improvement on the work of the NGO.

The office also receives advice and support from two groups it has developed. The first of these is the Partnership Working Group (PWG), whose members are senior leaders drawn from the office's funding bodies, as well the Department of Health and Social Care. The PWG's purpose is to support the implementation of the National Guardian's work programme by providing insight and advice on emerging priorities and acting as a sounding board for ideas.

Liaison between the office and PWG members helps ensure the co-ordination of the organisations' respective work to support speaking up in healthcare.

The second of these groups is the Advisory Working Group (AWG), whose members are drawn from a range of backgrounds and interests. Their experience, knowledge and expertise on issues associated with speaking up, and the complexities of implementing change in the NHS inform the development of the office's work.

Structure

The National Guardian for the NHS is supported by a team consisting of 18 London or home-based members of staff as at December 2020.

Finances

The NGO was allocated an annual budget of £1,666,657 and spent a total of £1,349,844 in 2019-20.

Prescribed Person

The NGO is a 'prescribed person' for the purposes of s.43F of the Public Interest Disclosure Act 1998. The office annually reports on the number of 'qualifying disclosures' workers have made to it and how it has responded to those disclosures.

Contacts

For more information about the National Guardian's Office visit **www.nationalguardian.org.uk**

You can contact the office by emailing **enquiries@nationalguardianoffice.org.uk**

Or phone us on **0191 249 4400**

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National Guardian's Office
Annual Report 2020

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National Guardian
Freedom to Speak Up

ALERT | ADVISE | ASSURE (AAA)
Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	24 MAY 2021
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The committee were advised that the anticipated income the Trust will receive from the Health Care Partnership (HCP) in 2021-22 will be materially lower than planned. Mitigation measures are being identified to help ensure the Trust can deliver a break-even position this financial year. The implications of this will be included within the financial plans submitted for Board approval in June 2021.
- With regards to future funding arrangements beyond 2021-22, there is continued uncertainty on what financial model will be applied if the current system is felt to be unsustainable.

ADVISE

- The committee received a Cost Improvement Plan (CIP) update, which illustrated £2.5M of CIP opportunities that have been identified. An Efficiency Board has been established to oversee corporate functions, whilst the PIDA cycle will oversee opportunities generated through the Clinical Business Units (CBUs). The committee emphasised the importance of delivering CIP targets, particularly in light of the lower forecasted income the Trust will now receive in 2021-22.
- The Trust has secured an additional £1.33M capital funding from regional Public Dividend Capital (PDC).
- A review schedule of approved business cases was presented to the committee. This will be led by the Business Case Implementation Group (BDIG) and will focus upon benefit realisation and lessons learned. A summary of review outcomes will be reported through to FP&I Committee.
- In regard to future business cases and investment need, the committee highlighted the cost and affordability of potential service redesign linked to the Trust's Strategic Plan. It was suggested the committee could play a pro-active role in the process on behalf of the Board.
- The committee received the RTT Restoration Operational Plan, and it was reported that the Trust is on-track against plan, with RTT performance currently at 83.1%. The number of 52-week waiters and Priority 2 patients has reduced within the last month, however, it was highlighted that returning to pre-covid productivity levels will be difficult whilst enhanced Infection Prevention Control (IPC) measures remain in place.
- The committee received the Urgent Care Performance report, which has been submitted to NHSE and illustrates the Trust's future performance trajectory in urgent care and the high impact actions that will enable that to be reached.
- The IM&T Committee alerted FP&I to a risk that incorrect patient locations would be generated, caused by a duplicate interface message being sent by Medway to EMIS. Mitigation measures had been put in place through the involvement of the Pharmacy Team to prevent any risk to patient safety.
- The Committee received a revised set of finance indicators through the IPR and, whilst these were generally well received as an improved set of indicators, it was agreed that further work was required to provide historical data for comparative purposes.

ASSURE

- The Committee received and approved the Procurement strategy, subject to it including an implementation plan that includes measurable outputs and milestones.

New Risks identified at the meeting:
None

Review of the Risk Register: *No action taken*

Operations

Access

Analyst Narrative:

Three indicators within this section are failing their assurance measure; A&E – 4 hour compliance, Ambulance Handover 30-60 mins and Diagnostic Waits. A&E 4 hr performance has declined in April and shows special cause concern, impacted by an increasing number of attendances. Ambulance Handover 30-60 mins is showing positive variation, maintaining performance below the 3rd lower control limit. Ambulance Handover over 60 Mins is also showing positive variation. Diagnostic waits has increased marginally in April although this is not statistically significant.
All RTT indicators continue to show special cause concern due to the ongoing effect of the Covid pandemic, although the number of 52 week waits has reduced by over 26% from March to April as the Trust implements its restoration plan.

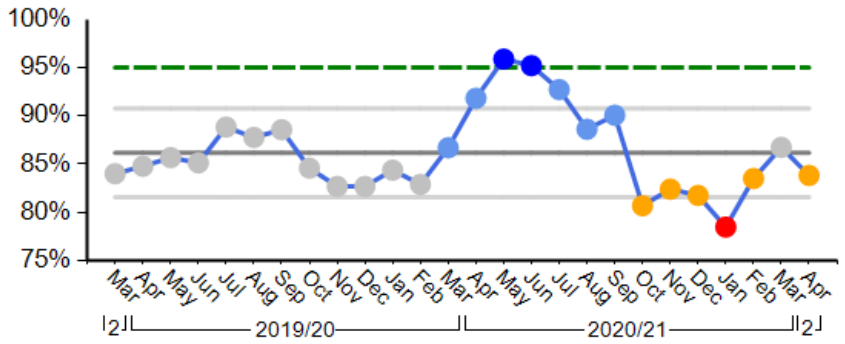
Operational Narrative:

A&E – Attendances have increased significantly, SDGH has seen a 9% increase from March to April. SDGH Majors have increased by 4% significantly impacting on A&E flow and performance. Rate in admissions shifted and LOS increased and there were significant occupancy issues in the department. Trust surge in line with Cheshire and Mersey for presentation and occupancy levels. Urgent and Emergency Care Improvement Group established with key work streams to drive improved performance in this area.

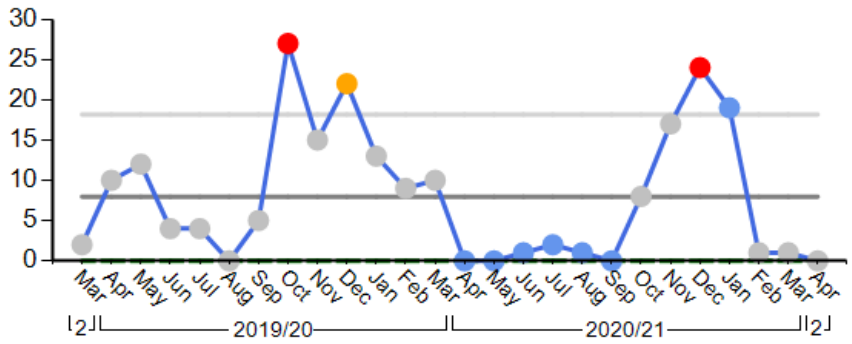
Please also refer to supplementary action plans for Diagnostic Waits and RTT.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	83.8%	1461	Apr 21	L	95%	86.7%	Mar 21	95%	83.8%	F
Accident & Emergency - 12+ Hour trolley waits	0	0	0	Apr 21		0	1	Mar 21	0	0	?
Ambulance Handover 30-60 Mins	0	30	30	Apr 21	L	0	22	Mar 21	0	30	F
Ambulance Handover Over 60 Mins	0	8	8	Apr 21	L	0	1	Mar 21	0	8	?
Diagnostic waits	1%	15.5%	630	Apr 21		1%	14.6%	Mar 21	1%	15.5%	F
Referral to treatment: on-going	92%	82.1%	1850	Apr 21	L	92%	81.5%	Mar 21	92%	82.1%	?
Total RTT Waiting List - Trust		10352	10352	Apr 21			9897	Mar 21		10352	?
52 Week Waits	0	242	242	Apr 21	H	0	330	Mar 21	0	330	?
Total 52 week waits – completed		122	N/A	Apr 21	H		82	Mar 21		122	?

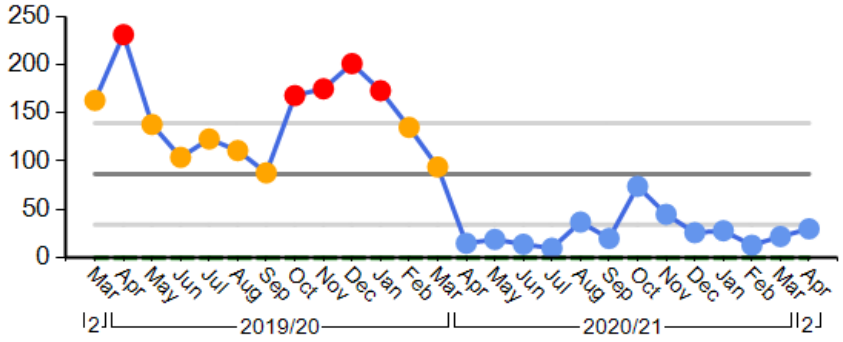
Accident & Emergency - 4 Hour compliance



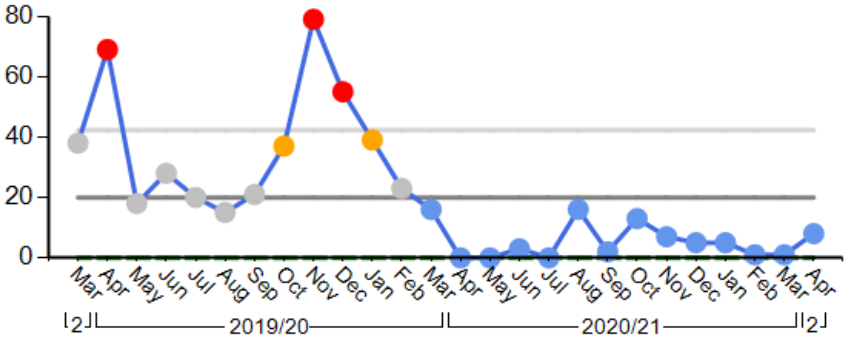
Accident & Emergency - 12+ Hour trolley waits



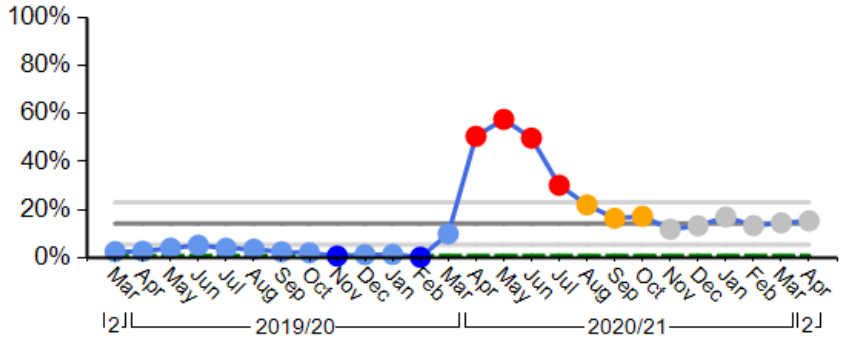
Ambulance Handover 30-60 Mins



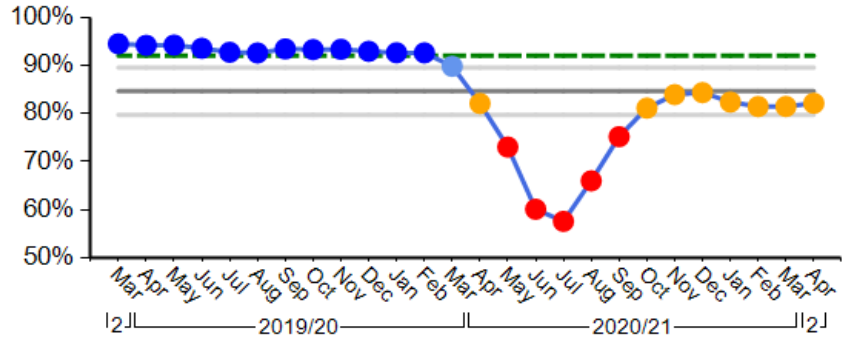
Ambulance Handover Over 60 Mins



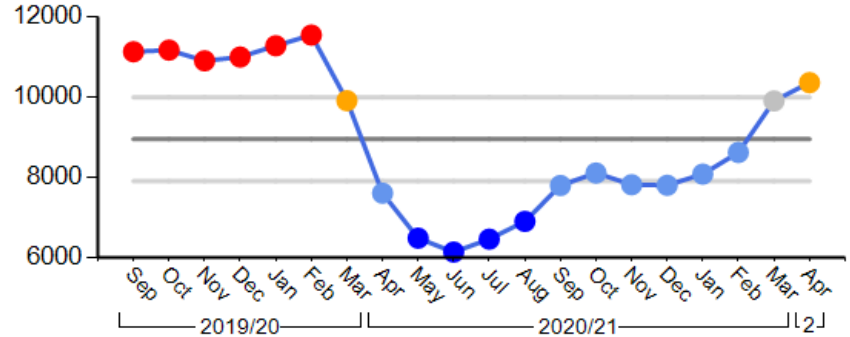
Diagnostic waits



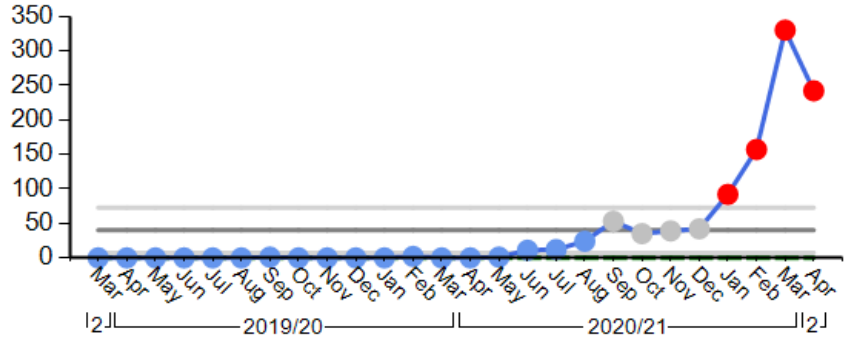
Referral to treatment: on-going



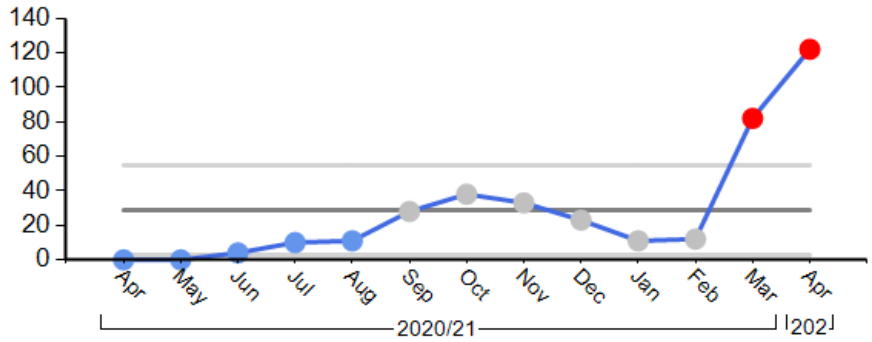
Total RTT Waiting List - Trust



52 Week Waits



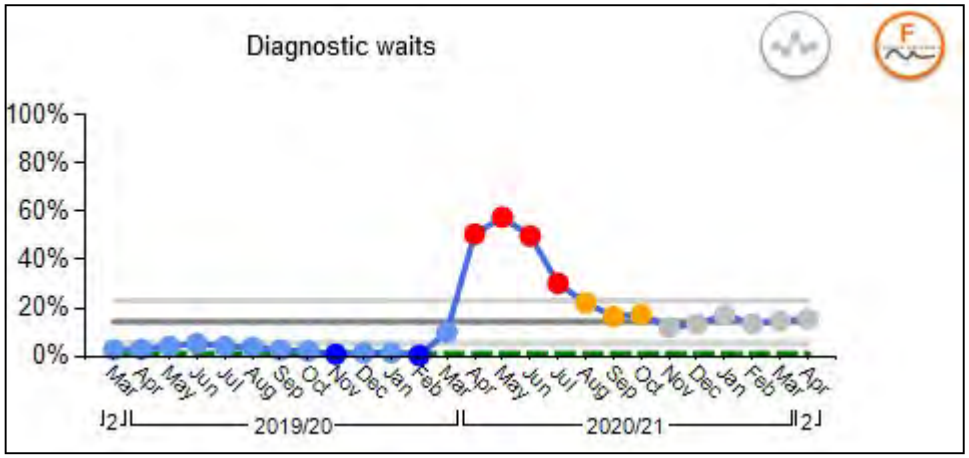
Total 52 week waits – completed



Diagnostic Waits

NHS
Southport and Ormskirk Hospital
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Diagnostic waits	1%	15.5%	630	Apr 21		1%	14.6%	Mar 21	1%	15.5%	



Background:

The diagnostic operational standard is that less than 1% of patients should wait 6 weeks or more for a diagnostic test.

Situation:

Performance against this standard has been impacted by the Covid pandemic. Whilst there was recovery following the first wave this recovery has stalled since Autumn with the return of Covid and pressures on the service.

Issues:

Capacity restrictions remain in place due to social distancing.

Challenges within Radiology Consultant workforce with continued difficulties being able to recruit.

Workforce constraints within some diagnostic procedures including some single point of failures.

Significant increase in demand, particularly in Endoscopy.

Reduction in face to face assessments.

Estates work within Endoscopy not on capital plan for 2021/22.

Actions:

Additional activity requested and improved via WLI's and insourcing, this will be ongoing to improve recovery position and reduce wait times.

Additional CT capacity is being sought from St Helen's and Knowsley Trust

Recruitment to Radiology Consultant post.

Commence FIT testing for surveillance patients in April which will free additional capacity to manage increase in 2ww demand.

Estates work in Endoscopy escalated to Risk Register.

Mitigations:

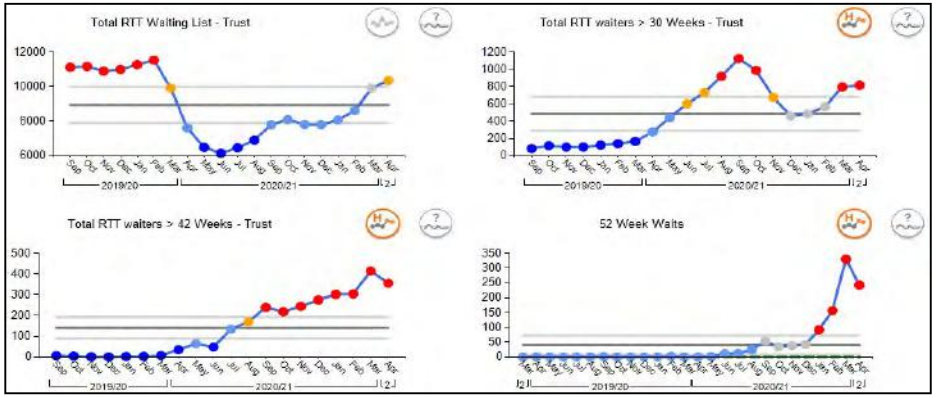
Recovery plans are in place.

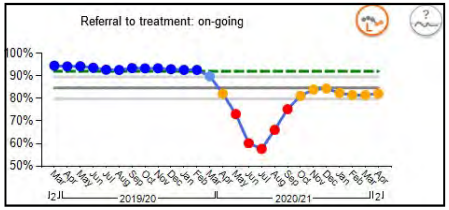
Ongoing validation of DM01 patient tracking list

Referral to Treatment

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referral to treatment: on-going	92%	82.1%	1850	Apr 21		92%	81.5%	Mar 21	92%	82.1%	
Total RTT Waiting List - Trust		10352	10352	Apr 21			9897	Mar 21		10352	
Total RTT waiters > 30 Weeks - Trust		814	814	Apr 21			794	Mar 21		814	
Total RTT waiters > 42 Weeks - Trust		355	355	Apr 21			414	Mar 21		355	
52 Week Waits	0	242	242	Apr 21		0	330	Mar 21	0	330	





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 but the number of 42 and 52 week waiters has decreased.

Issues:

15 specialities are currently failing.

Referrals into the Trust continue on an upward trend.

The ongoing issues of estate and sickness remain.

Bed occupancy at SDGH remains high.

Ongoing requirements for patients to undertake Covid tests and self-isolate.

Concerns over increasing workload requirements with Community Services.

Possible requirement to support other Trusts 52 week position.

Actions:

All P2 patients to be dated, as a minimum, if not treated within 28 days.

Theatres have reverted to 6 week notice period in May which will have the benefit of specialties being able to have the knowledge and confidence that a list will go ahead on a particular day.

Management of sickness absence within theatres and organisational development being undertaken.

Extra weekend sessions in place.

The Trust now has a sub-contract with Renacres to deliver activity as part of the Trust recovery plan.

Meetings with the CCGs to highlight Community workload concerns, CCGs have asked Community to produce plans as to how to deliver that support.

Mitigations:

Recovery plans are in place across all specialities and a Restoration Plan has been submitted. Currently meeting targeted restoration activity levels as per national guidance.

The Trust continues to Clinically Prioritise surgical waiting lists as per the Federation of Surgical Specialty Association (FSSA)/ NHSE Clinical Guide to Surgical Prioritisation.

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

Use of virtual appointments where possible

Operations

Cancer

Analyst Narrative:

The 14 day GP referral to Outpatients continues to show special cause concern although there has been an increase in March. This remains a cause for concern. The 31 day treatment was again ahead of plan in March; this performance needs to be sustained to be assured. Whilst not statistically significant, performance on the 62 day GP referral indicator has declined in March. This requires further narrative.

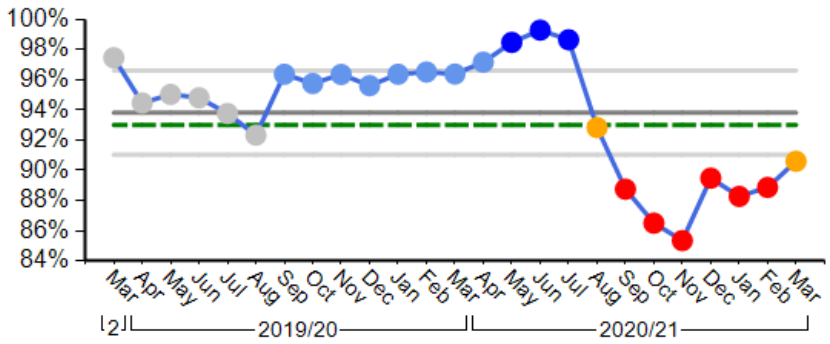
Operational Narrative:

Although compliance against the 14-day target continues to fall below the 93% threshold, numbers of actual referrals were 33% higher in March than Feb and 944 patients were seen in time – the highest level in the last 12 months. The numbers of patients treated against the 31-day target were also at the highest level this quarter, and we were comfortably compliant against this standard. This reflects our careful management of the reduced theatre capacity locally due to COVID. Our 62-day performance continues to be challenged by similar theatre capacity restrictions in tertiary trusts, as well as diagnostic delays locally where COVID is still impacting on our capacity, for example in endoscopy. Actual covid testing of patients attending for diagnostics is causing some delays in scheduling by restricting short notice bookings and with some patients needing to be tested several times. Most patients are now happy to come into the Trust for appointments, no longer deterred by the fear of catching COVID whilst on site. This is improving the pathways for many, but also challenging our capacity in several diagnostic services, primarily endoscopy and radiology.

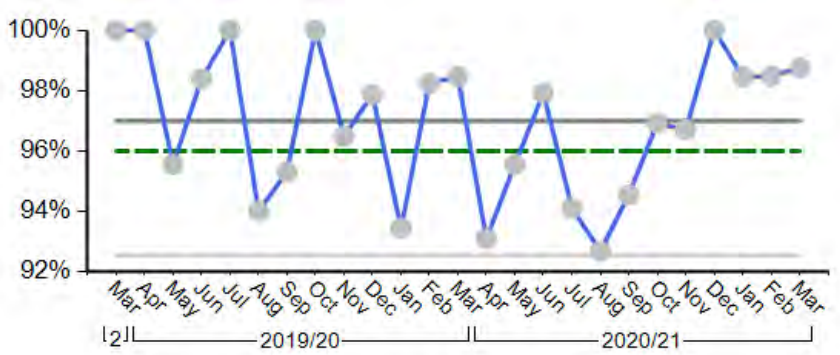
Please also see supplementary action plan for the 14 day GP referral to Outpatients.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	90.6%	98	Mar 21		93%	88.9%	Feb 21	93%	91.3%	
31 day treatment	96%	98.8%	1	Mar 21		96%	98.5%	Feb 21	96%	96.8%	
62 day GP referral to treatment	85%	70.9%	16	Mar 21		85%	72.8%	Feb 21	85%	76.9%	

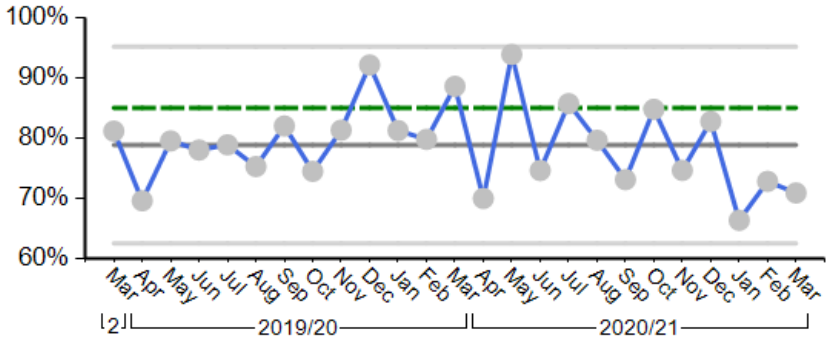
14 day GP referral to Outpatients



31 day treatment



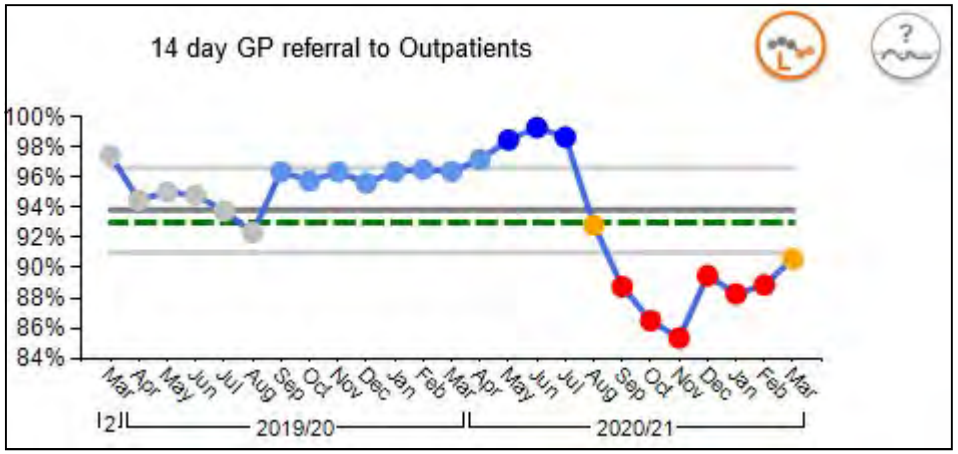
62 day GP referral to treatment



Cancer - 14 day GP Referral to Outpatients

Southport & Ormskirk Hospital NHS
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
14 day GP referral to Outpatients	93%	90.6%	98	Mar 21		93%	88.9%	Feb 21	93%	91.3%	



Situation: 14 Day cancer performance is still below the compliance threshold, but is gradually improving. Numbers of patients reported against this target is at its highest level since July 2019 (and the second highest ever recorded).

Issues:

The Trust was not compliant for the 14 day national standard. COVID continues to have a significant impact on our ability to provide timely services.

14 day target – failure of this target is primarily around patients who are on straight to test pathways for urology, lower and upper GI. Incorrectly completed referrals for urology which are sent in without bloods have delayed scans in radiology. The endoscopy department continues to have issues around staffing and capacity. In spite of this ,all of these tumour sites have seen some improvement against the standard. However, demand continues to increase in all these areas, with referrals 33% higher than in February, preventing all patients from being seen on time.

Actions:

Activity in endoscopy has returned to pre-COVID levels, but capacity cannot keep up with demand for tests. In addition to restrictions resulting from the need for single-sex lists, staff illness continues to restrict activity. Estates are expected to set out timescales for the completion of the building of new changing facilities, required for mixed sex lists to resume,, this month.

Haematuria pathway audit continues and a meeting between the lead cancer nurse and the CCGs has taken place to review initial results.

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. The small improvement seen against standard is attributed to this..

An Endoscopy Improvement group has been set up this month to discuss the department utilisation, DNA rates and internal KPIs.

A new Cancer Improvement Project Manager has been appointed and is to commence in post in June.

Operations

Productivity

Analyst Narrative:

The IPR review undertaken has resulted in changes to some of the targets and the addition of some metrics within this section.
One indicator is failing its assurance measure; Bed Occupancy – ODGH. Theatre Utilisation, which had been failing assurance for several months, is now showing intermittent assurance as the new target, which considers the impact of Covid, has been applied. Bed Occupancy continues to show special cause concern, although performance in April is at its highest level since before the pandemic. Both stranded and super-stranded patient metrics have increased in April and the A&E Conversion rate has declined significantly in April, due to an increase in minors attendances. Outpatient slot utilisation shows special cause improvement, with performance in April just 1.1% below plan.

Operational Narrative:

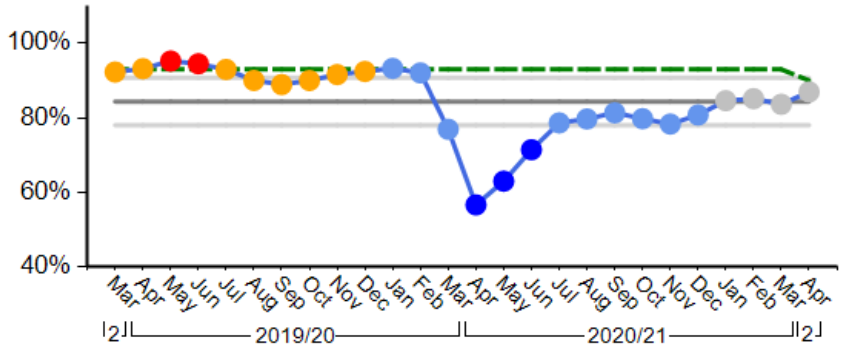
April saw a peak of stranded (184) and super stranded patients. There has been a positive response from system partners to support reduction of Ready for Discharge days and renewed focus in moving patients through the system. 10 beds remain open and fully utilised at Birkdale Park and Ward 1 escalation was open over the Easter weekend. Since December there have been 9 escalation beds open as a minimum – 3 on AMU and 6 on SSS.

Out-patient slot utilisation is improving and work ongoing to ensure clinic templates are appropriate and blocked where needed. Trust wide out-patient project re-starts in May specifically looking at clinic utilisation.

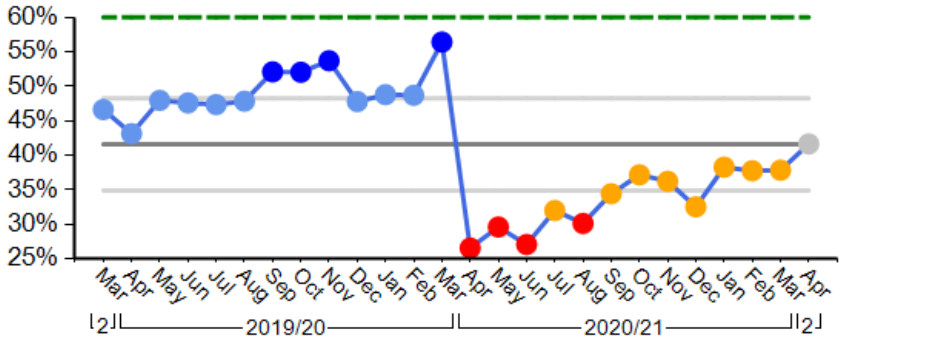
Please also refer to supplementary action plans for Bed Occupancy – ODGH, Theatre Utilisation and LoS/Standed Patients.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	90%	86.9%	N/A	Apr 21		93%	83.6%	Mar 21	90%	86.9%	
Bed Occupancy - ODGH	60%	41.6%	N/A	Apr 21	L	60%	37.8%	Mar 21	60%	41.6%	F
Stranded Patients (>6 Days LOS)	163	162	162	Apr 21	L	170	148	Mar 21	163	162	
Super Stranded Patients (>20 Days LOS)	53	48	48	Apr 21	L	58	41	Mar 21	53	48	
OP Slot Utilisation	95%	93.9%	N/A	Apr 21	H	95%	90.4%	Mar 21	95%	93.9%	
New:Follow Up	2.63	2.3	N/A	Apr 21		2.6	2.5	Mar 21	2.63	2.3	
DNA (Did Not Attend) rate	7%	5.8%	1178	Apr 21		8%	5.6%	Mar 21	7%	5.8%	
Theatre Utilisation - SDGH	75%	64.3%	N/A	Apr 21		85%	66.6%	Mar 21	75%	64.3%	
Theatre Utilisation - ODGH	75%	69.7%	N/A	Apr 21		95%	67.5%	Mar 21	75%	69.7%	
Southport A&E Conversion Rate	28%	21.9%	1083	Apr 21	H	28%	28.4%	Mar 21	28%	21.9%	

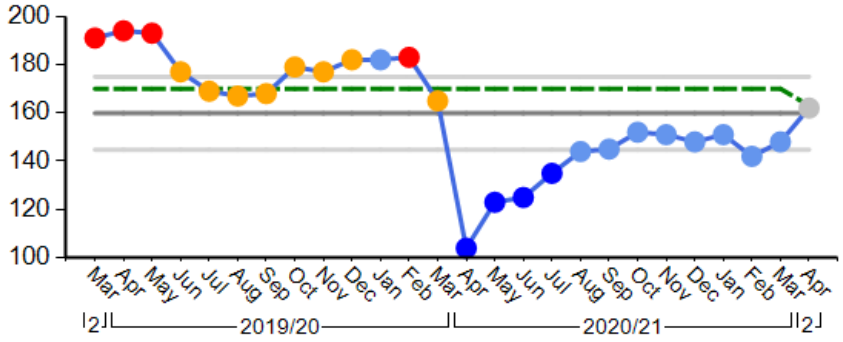
Bed Occupancy - SDGH



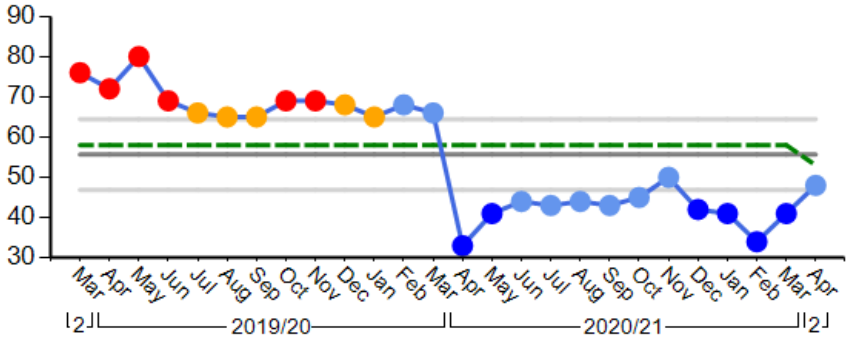
Bed Occupancy - ODGH



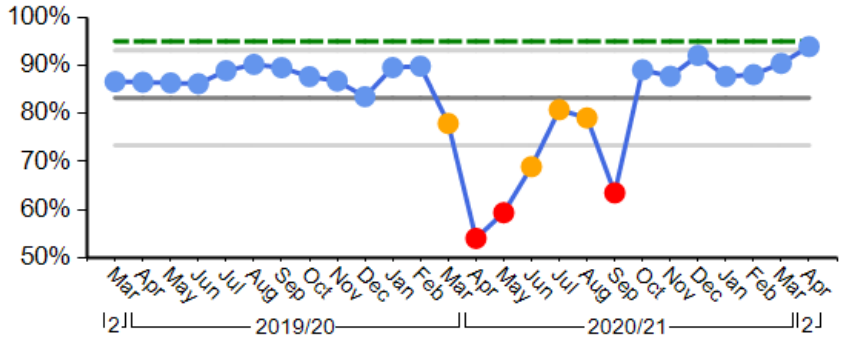
Stranded Patients (>6 Days LOS)



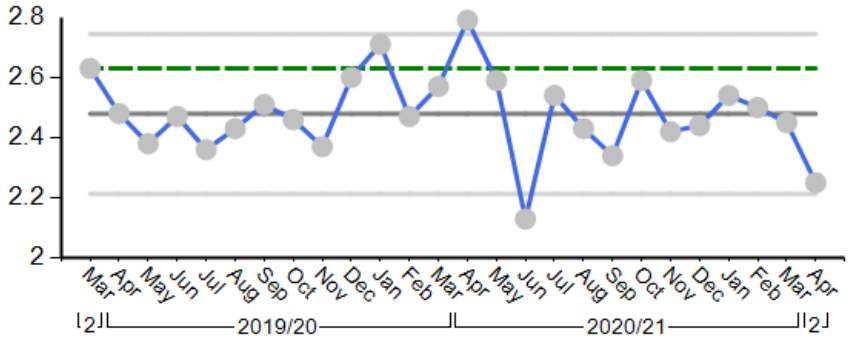
Super Stranded Patients (>20 Days LOS)



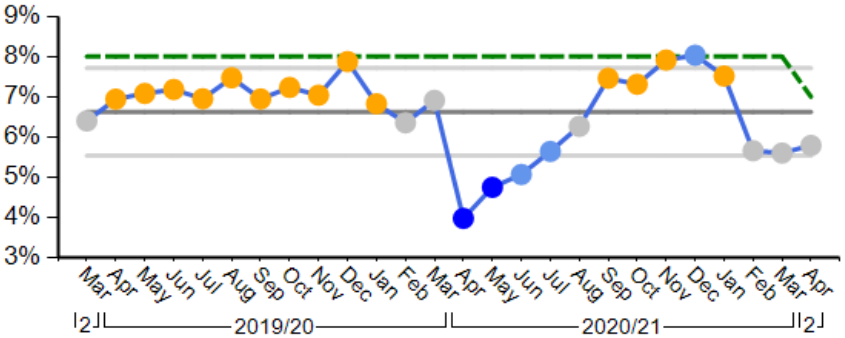
OP Slot Utilisation



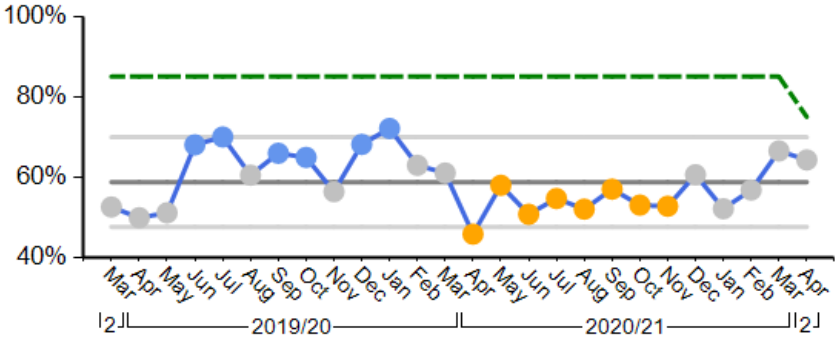
New:Follow Up



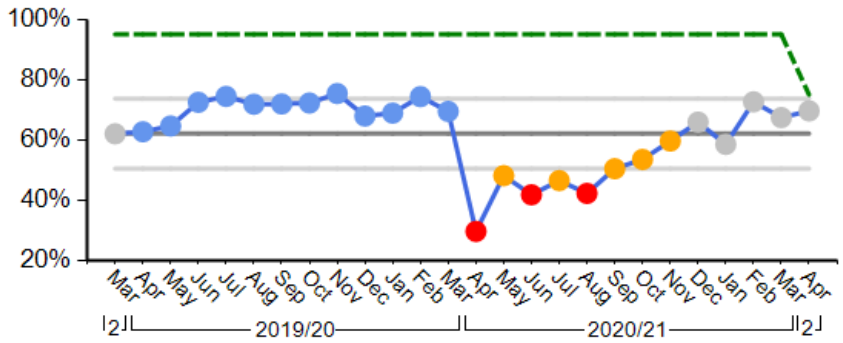
DNA (Did Not Attend) rate



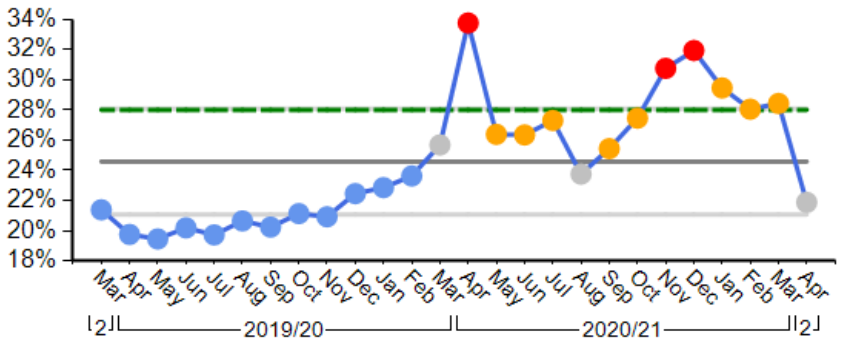
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



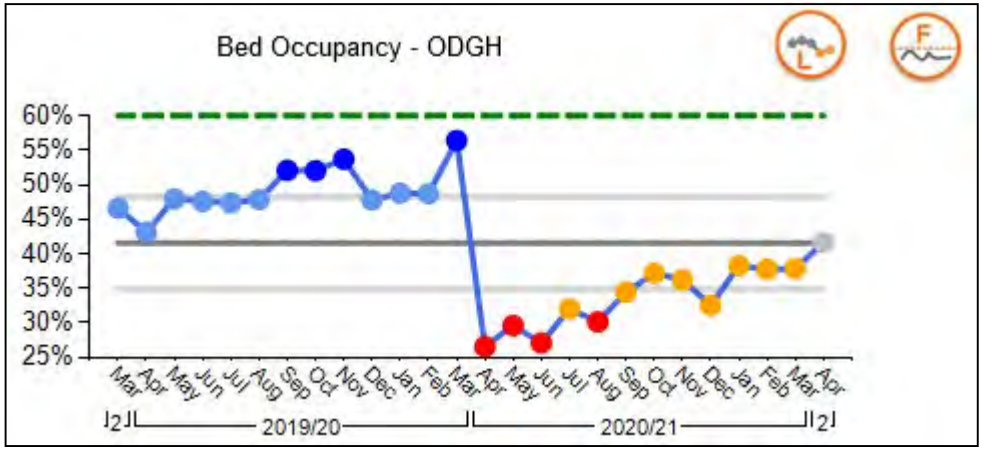
Southport A&E Conversion Rate



Bed Occupancy—ODGH

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Bed Occupancy - ODGH	60%	41.6%	N/A	Apr 21		60%	37.8%	Mar 21	60%	41.6%	



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.

There has been an increase in occupancy in April due to the increase in theatre activity.

Issues:

H Ward remained closed in April and F Ward was only open for part of the month.

Overall occupancy on this site is impacted by Maternity and Paediatrics.

Actions:

Theatre lists will increase to 5 lists per day at ODGH with effect from 17th May.

Additional beds will open on G Ward in response to the closure of Ward 11A.

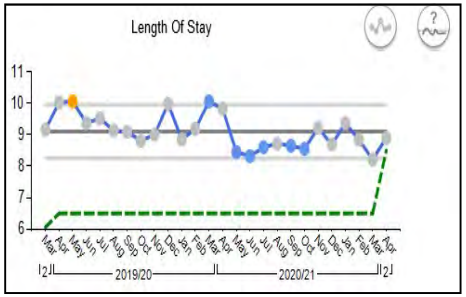
Mitigations:

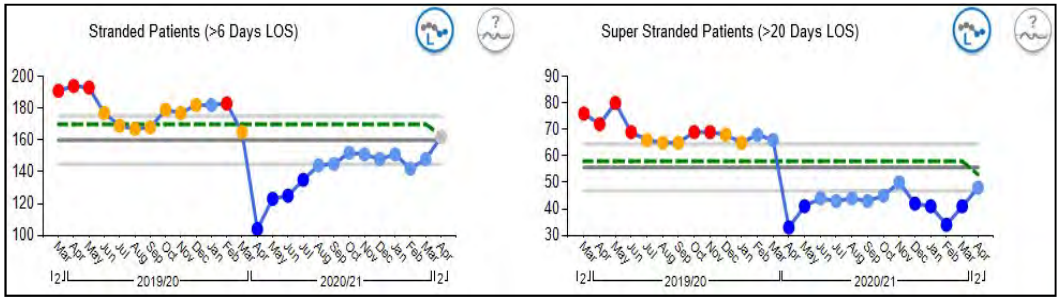
BI have created a number of internal reports to look at ward bed occupancy on a daily and monthly basis. It also shows the constitution of activity within each ward which helps to explain how each ward is being utilised for patient care.

Length of Stay

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Length Of Stay	8.5	8.9	N/A	Apr 21		6.5	8.2	Mar 21	8.5	8.9	
Stranded Patients (>6 Days LOS)	163	162	162	Apr 21		170	148	Mar 21	163	162	
Super Stranded Patients (>20 Days LOS)	53	48	48	Apr 21		58	41	Mar 21	53	48	





Back-ground:

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

Situation:

The plan of 6.5 has been updated to 8.5 to align with Model Hospital benchmarked average. Current average LOS is 8.9. Number of stranded and super-stranded patients has increased in April.

Issues:

There was a 9% increase in attendances at A&E from March to April. Majors have increased by 4% which has impacted A&E performance and patient flow.

Bed occupancy has increased to 86.9% at SDGH with a paucity of discharges early in the week and there has been an increase in length of stay.

April saw a peak of stranded (184) and super stranded patients.

Actions:

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

Clinical matrons and ward managers have been requested to ensure appropriate challenge is in place at ward level against the national criteria to reside. The Head of Patient Flow has been supporting some wards at board rounds.

The daily task force continues and the Flight Controller role has been maintained, with continued positive response from system partners.

Utilisation of 10 beds at Birkdale Park and Ward 1 escalation open over Easter weekend.

The Head of Patient Flow has resurrected the SAFER project focusing on effective board and ward rounds using technology in order partners can join the board rounds virtually to support decision making.

Mitigations:

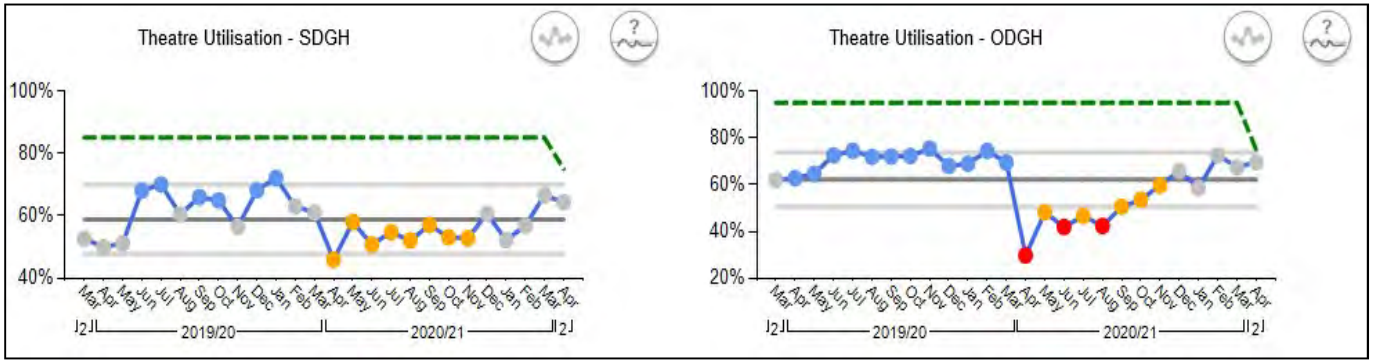
Patients are managed based on their “reason to reside”; when they no longer meet the range of conditions under this criterion, they must be placed into an alternative setting for discharge planning if they cannot be discharged to their own home.

System wide capacity and flow meeting continues to meet twice weekly to address any ongoing issues or pressures in the system.

Theatre Utilisation

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Theatre Utilisation - SDGH	75%	64.3%	N/A	Apr 21		85%	66.6%	Mar 21	75%	64.3%	
Theatre Utilisation - ODGH	75%	69.7%	N/A	Apr 21		95%	67.5%	Mar 21	75%	69.7%	



Background: The proportion of elective Theatre slots used over the total elective planned capacity. Split by the site of delivery.

Situation: The plan for both sites has been amended to 75% to reflect the current Covid restrictions. A further increase in utilisation noted at ODGH, a slight decline at SDGH but remains above the mean.

Issues:

Utilisation in April at SDGH was impacted by bed pressures.

Theatre utilisation was impacted by both late starts and under-runs in April, 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. This includes the use of additional beds opening on G Ward in response to the closure of Ward 11A.

Look to add in P3/P4 52ww fillers to improve utilisation.

Currently reviewing the flow through Theatre with Covid on the Southport site to see if throughput can be increased.

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.

Finance

Finance

Analyst Narrative:

The majority of indicators within this section are new, with only April 2021 data. As the SPC charts within this section are mostly based on one data point, there will be no assurance/variation indication.
The pay and non-pay run rates are subject to a special cause variation in March – pay impacted by our accrual for annual leave carry forward and non-pay relating a number of year-end adjustments including accounting for the national supply of PPE

Operational Narrative:

The plan is break-even for H1 (1st half of the financial year).

The plan for April is break-even and this has been achieved.

Pay run rate marginally above plan but mitigated by a similar underspend on non-pay resulting in break-even.

Bank and agency costs have reduced form Q4 levels, mainly reflecting the reduction in COVID associated expenditure.

Bank and agency costs represent 17% of total pay costs which highlights the potential for cost improvement if sickness levels can be reduced and vacancies can be filled substantively.

Agency costs were £0.9 million in April although this is the lowest level for over a year. Bank expenditure has risen but this a less costly option in nursing where most of the bank increase has taken place.

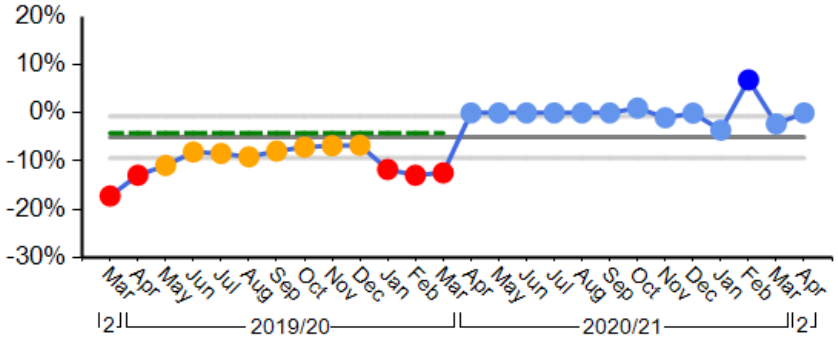
Premium rate pay expenditure (bank and agency) has reduced in April by £0.25 million. It is hoped that this falls further from the impact of international nurse recruitment.

The CIP Programme of £2.1 million for H1 is required in order to break-even (provisionally £4.2 million for the 2021/22). Whilst the programme is under construction the month 1 performance has been mitigated in order to deliver a break-even position.

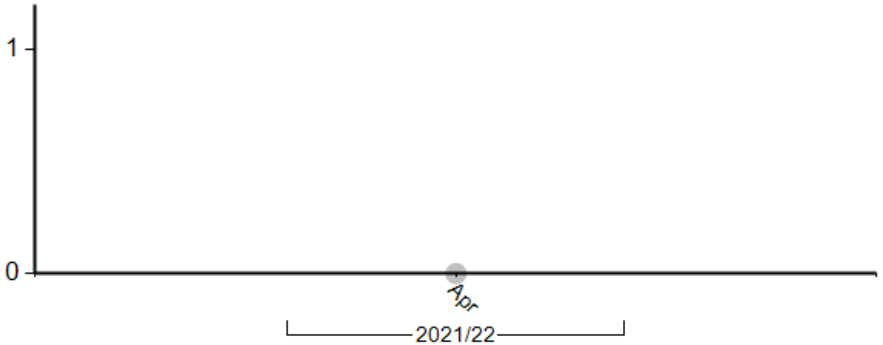
	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	0%	0%	N/A	Apr 21		-4.2%	-2.3%	Mar 21	0%	0%	
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0	0	N/A	Apr 21					0	0	
Pay Run Rate - Trust	£13,500K	£13600K	N/A	Apr 21			£16393K	Mar 21		£13,600K	
Non Pay Run Rate - Trust	£5,800K	£5700K	N/A	Apr 21			£9009K	Mar 21		£5,700K	

Budget in balance		Y	N/A	Apr 21						Y	
Budget in balance - forecast year end		Y	N/A	Apr 21						Y	
Bank & Agency Run Rate - Trust		£2310K	N/A	Apr 21			£2560K	Mar 21		£2,310K	
Bank & Agency Staff Run Rate (%)		17%	N/A	Apr 21						17%	
Agency Staff Run Rate (Cost)		£900K	N/A	Apr 21						£900K	
% Agency Staff (cost)		6.3%	N/A	Apr 21			5.6%	Mar 21	5%	6.3%	
Year To Date Reduction in Premium Rate pay		-£250K	N/A	Apr 21						-£250K	
CIP – Performance against Plan	£350K	£00K	N/A	Apr 21						£00K	
CIP – Forecast Outturn	£4,200K	£4200K	N/A	Apr 21						£4,200K	
CIP on Target		Y	N/A	Apr 21						Y	
Capital Spend – Performance against Plan	£400K	£300K	N/A	Apr 21						£300K	
Capital Spend – Forecast Outturn	£6,900K	£6872K	N/A	Apr 21						£6,872K	
Cash Balance	£6,800K	£7170K	N/A	Apr 21						£7,170K	

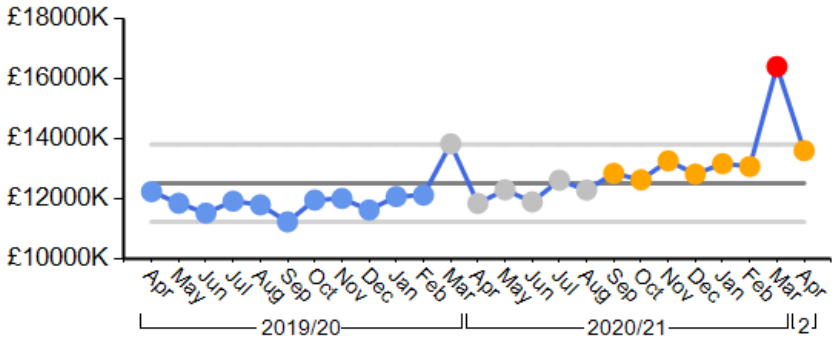
I&E surplus or deficit/total revenue



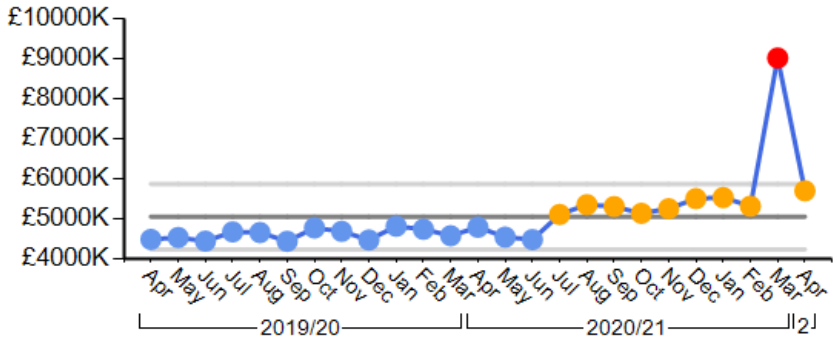
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



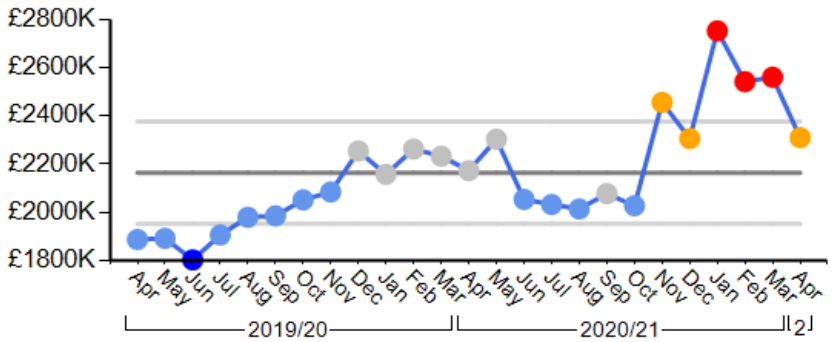
Pay Run Rate - Trust



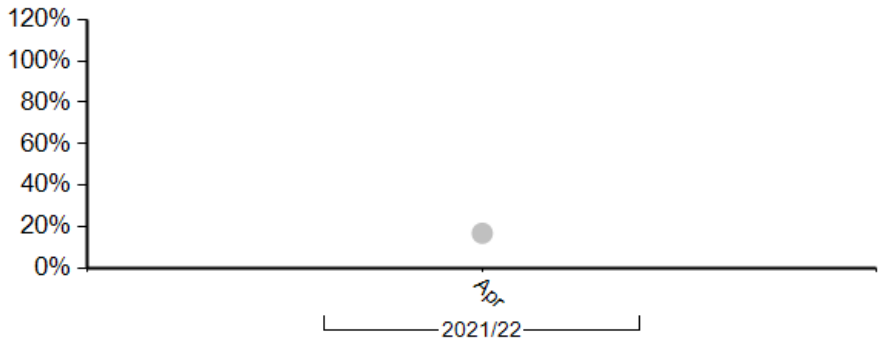
Non Pay Run Rate - Trust



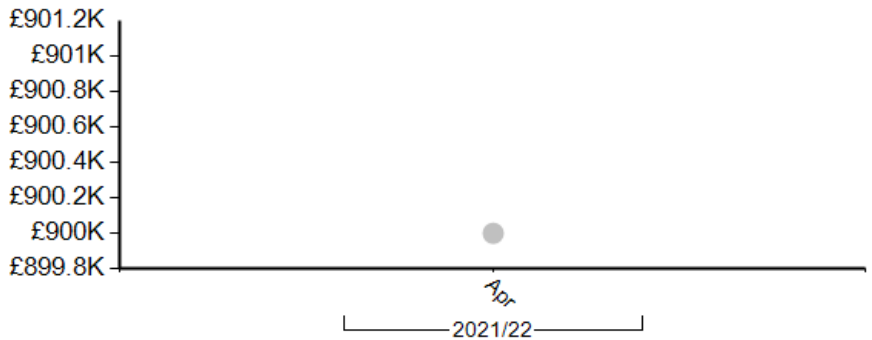
Bank & Agency Run Rate - Trust



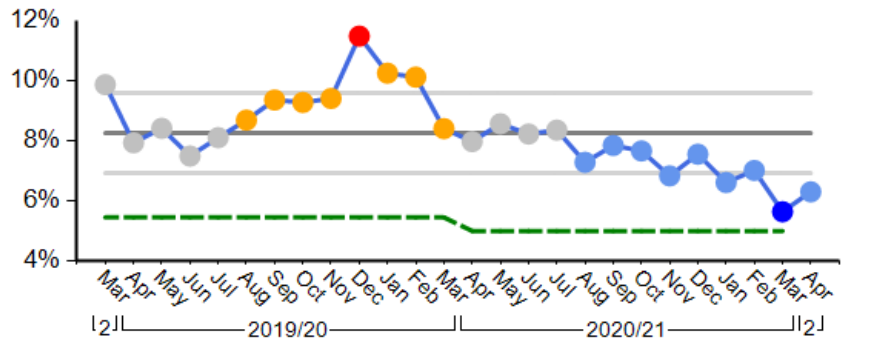
Bank & Agency Staff Run Rate (%)



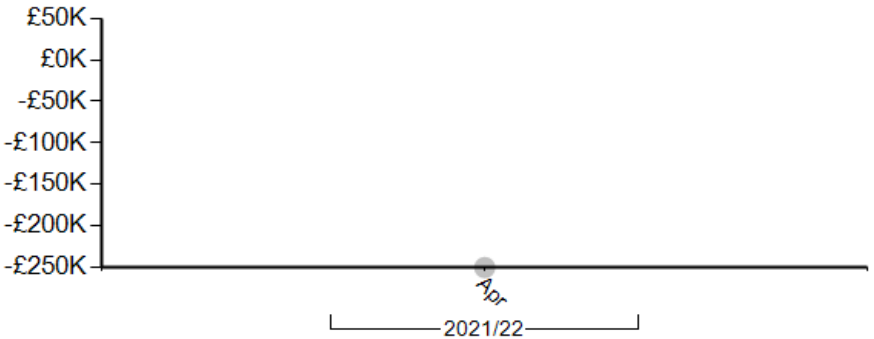
Agency Staff Run Rate (Cost)



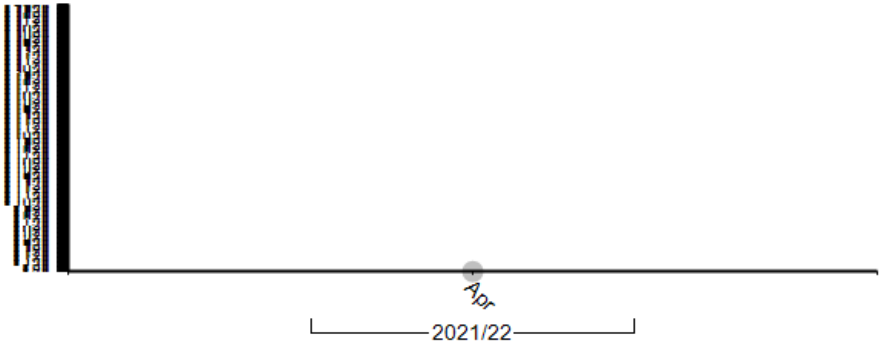
% Agency Staff (cost)



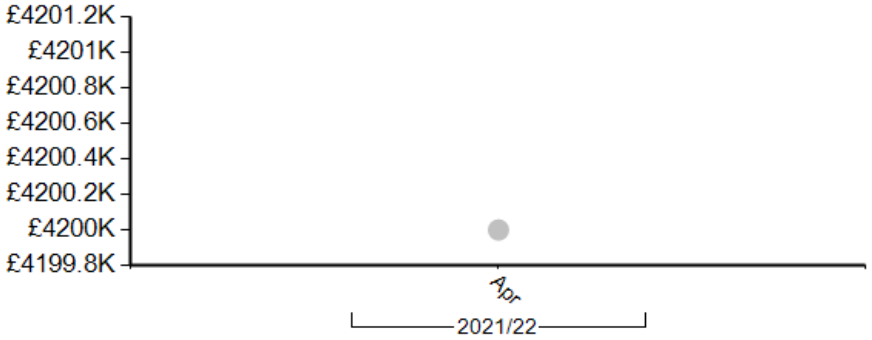
Year To Date Reduction in Premium Rate pay



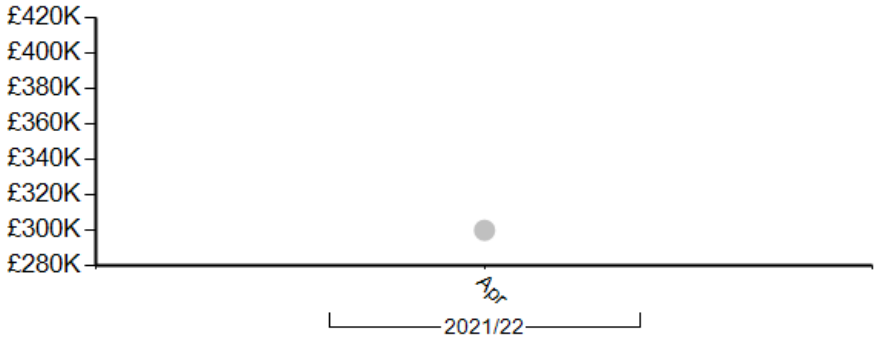
CIP – Performance against Plan



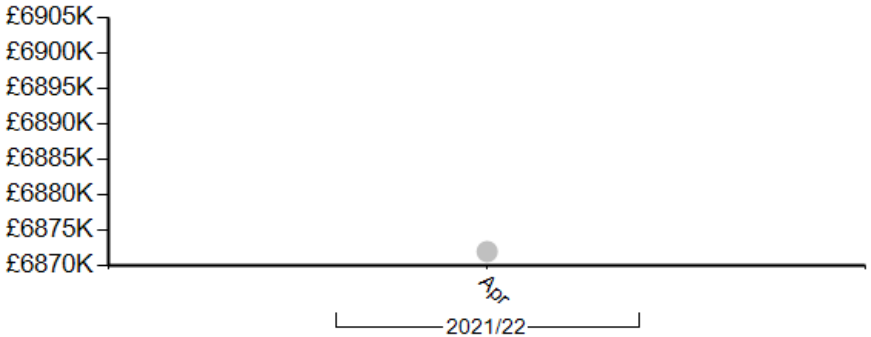
CIP – Forecast Outturn



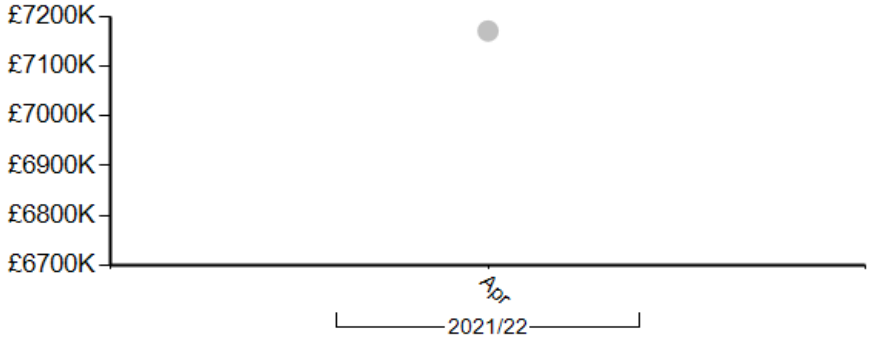
Capital Spend – Performance against Plan



Capital Spend – Forecast Outturn



Cash Balance



Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB097/21a**	**FOI Exempt**	**NO**
Report Title	**FINANCIAL PLAN 2021/22**		
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

Following the release of further information relating to the financial regime for the first half of 2021/22, this paper builds on the opening base budget position agreed at April Board of Directors meeting and provides the Board with an updated 2021/22 Financial Plan.

Executive Summary

This paper provides the assumptions that have been used to develop the Income & Expenditure and capital plans for 2021/22 and has been updated since FP&I to take account of the income changes following finalisation of resource allocation by C&M ICS and also the income and costs associated with achieving elective recovery targets.

The paper proposes a full budget which has been considered by FPI Committee on 24 May. The proposed budget is for H1 (first six months of the year) with an indicative budget for H2 pending further guidance.

The 2021/22 plan is to deliver financial balance for H1 and the year as whole, however there remains an unmitigated financial pressure of £3.7 million in H1, and £7.4m in the full year based on the current plan assumptions.

The downside scenario is that NHS Block contract income reduces by a further 3% in H2 resulting in an increased gap of £7.0m in H2, and total gap of £10.7 million for the full year.

There are four potential ways of mitigating the above gap:

- Productivity improvements – by using marginal increases in cost to deliver additional activity above the planned contribution of £0.8 million from the Elective Recovery Fund.
- Run rate reduction – by avoiding potential expenditure included in the financial plan including Covid/Winter costs c£3.0m and run rates in excess of current budgets £2.9m
- Curtailing planned expenditure – by managing the discretionary investments within the resources available
- Cost Improvement Programme (CIP) – currently identified schemes totalling £2.5m for the full year.

Capital priorities have been reviewed by the Executive and the initial £4.5m capital budget allocated as follows:

- Medical equipment - £0.75m
- Essential Fire works - £1.00m
- Backlog maintenance - £0.75m

- IM&T - £1.00m
- Strategic Schemes - £1.00m

Recommendations

The Board is asked to **approve** the setting of a break-even plan for H1 and the indicative for H2 plan (still subject to resource allocation confirmation). This will then form the basis for our final plan submission via the ICS to the NHSEI and budgetary control system.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Kevin Walsh	Bill Gregory

NHS
Southport and Ormskirk Hospital
NHS Trust

Financial Plan 2021/22 Update

1. Purpose

1.1. Following the release of further information relating to the financial regime for the first half of 2021/22, this paper builds on the opening base budget position agreed at April Board of Directors and provides the Board with an updated 2021/22 Financial Plan.

2. Executive summary

2.1. This paper provides the assumptions that have been used to develop the Income & Expenditure and capital plans for 2021/22, and has been updated since FP&I to take account of the income changes following finalisation of resource allocation by C&M ICS and also the income and costs associated with achieving elective recovery targets.

2.2. The paper proposes a full budget which has been considered by FPI Committee on 24 May. The proposed budget is for H1 (1st six month of the year) with an indicative budget for H2 pending further guidance.

2.3. The 2021/22 plan is to deliver financial balance for H1 and the year as whole, however there remains an unmitigated financial pressure of £3.7 million in H1, and £7.4m in the full year based on the current plan assumptions

2.4. The downside scenario is that NHS Block contract income reduces by a further 3% in H2 resulting in an increased gap of £7.0m in H2, and total gap of £10.7 million for the full year.

2.5. There are four potential ways of mitigating the above gap:

- Productivity improvements – by using marginal increases in cost to deliver additional activity above the planned contribution of £0.8 million from the Elective Recovery Fund.
- Run rate reduction – by avoiding potential expenditure included in the financial plan including Covid/Winter costs c£3.0m and run rates in excess of current budgets £2.9m
- Curtailing planned expenditure – by managing the discretionary investments within the resources available
- Cost Improvement Programme (CIP) – currently identified schemes totalling £2.5m for the full year.

2.6. Capital priorities have been reviewed by the Executive and the initial £4.5m capital budget allocated as follows:

- Medical equipment - £0.75m
- Essential Fire works - £1.00m
- Backlog maintenance - £0.75m

- IM&T - £1.00m
- Strategic Schemes - £1.00m

2.7. The Board is asked to approve the setting of a break-even plan for H1 and the indicative for H2 plan (still subject to resource allocation confirmation). This will then form the basis for our final plan submission via the ICS to the NHSEI and budgetary control system.

3. Introduction

3.1. Financial planning for 2021/22 is subject to a number of uncertainties including continuing costs of managing services through Covid-19, restoration and the financial regime that will be in place throughout the financial year

3.2. A report was presented at March's FPI Committee and April's Board outlining the approach to setting the financial plan based on information known at that time.

3.3. Since then further iterations of the plan have been made based on national assumptions as well as income plans from the Cheshire & Merseyside Health Care Partnership (C&M HCP)

3.4. The first system level planning submission to NHSEI was made on 5 May which was for H1 only, and the forgoing plan incorporates the key elements of that plan affecting the Trust

3.5. The final planning submission will be made on 3 June, which will be followed by organisational level plans for in year monitoring purposes.

3.6. The main uncertainty regarding the Trust's H1 financial plan was the level of income. Much of this was dependant on the C&M HCP system resources and how these are allocated across NHS organisations within their footprint.

3.7. This financial plan is based on the latest set of income assumptions. The HCP confirmed the final position on 21 May which resulted in an income reduction of £2.4 million for H1. After the inclusion of planned restoration financial contribution of £0.8m, this effectively results in a financial gap of £3.7 million in H1 (previously £2.1 million prior to HCP income reduction)

3.8. Regardless of the uncertainties and potential late adjustments to the plan it is important that the Trust establishes a budget for the forthcoming year. This was agreed at April Board to be based on the rollover budget which has now been actioned and month 1 is being reported against this. However, with much clearer parameters around income it is appropriate we now publish our plan to live within the resources confirmed for H1 and indicatively for H2.

3.9. This paper provides the assumptions that have been used to develop the income and expenditure and capital plans for 2021/22 and proposes a full budget for approval by the Board following discussions at FPI Committee on 24 May.

3.10. The proposed budget is for H1 with an indicative budget for H2 pending further guidance.

3.11. The following sections on income and expenditure will reference the figures contained in Appendix 1.

4. Income

4.1. The HCP have now set the level of resources available for each NHS organisation and these have been used in order to set the 2021/22 budget.

4.2. The income assumptions are as follows:

- **NHS Income (including Top Up funding)** –This is based on the organisational resource envelope, which includes the top up. For the purposes of the base financial plan, we have assumed that a similar level of resource will be available in H2, but we have also modelled a downside scenario based of 3% less (based on informal soundings from NHSEI). The resource envelopes include a modest inflationary uplift for specific issues (see below in expenditure) offset by a minimum efficiency requirement of 0.28%.

- **Non-NHS income** –This includes car parking income, retail rents and recharges to local authorities. During Covid-19, revised recharge rules and separate reimbursement of lost non-NHS income has been provided by NHSEI. Any similar offset is included in the Covid-19 funding below. The plan therefore continues to be based on an average of January and February 2021 actual income (which has markedly improved against Q3 levels). These assumptions will be further validated once more information becomes available.

- **Education income** – this is based on 2020/21 actuals, confirmation as to 2021/22 funding levels will not be available from HEE before June 2021.

- **Covid-19 funding** – this is for IPC and maintaining social distancing arrangements, but now also to cover other disruption costs including loss of non-NHS income. The amount initially increased from £6.5 million in 2020/21 H2 to £6.9 million in 2021/22 H1 (£13.8 million in the full year), partly reflecting inflation and partly to offset lost non-NHS income referred to above. The notification from HCP of a further £2.4m income loss for H1 has been actioned against this resource (Mark has emailed Steve Barrow)

- **Restoration funding** – this will operate at a system level and is aimed at incentivising restoration of elective activity. Activity above the target threshold will be paid for on a Payment by Results (PbR) basis up to 85% of 2019/20 outturn levels and at 120% of PbR tariff above the 85% threshold. The HCP have now informed us that both income and expenditure forecasts should be included in the H1 plan. The latest estimate suggests the Trust could generate a contribution of £0.8 million in H1 if it delivers the activity plan. Effectively this means that the forecast £0.8 million contribution from the

ERF will partially mitigate the £4.5 million financial gap for H1, albeit on a non-recurrent basis.

5. Expenditure

5.1. **Base budgets** for CBU and corporate functions have been developed using the following principles:

- Pay budget – based on agreed establishment
- Non-Pay budget – based on 2019/20 outturn
- Add/deduct for any agreed in year issues e.g. legal costs, visas, international nurse recruitment (unless funded)
- Identify unavoidable pressures e.g. Office 365 licences
- Agree a budget to reflect the impact of premium rate expenditure associated with the recruitment to vacancies.
- Identify full year effect of anything started in year e.g. Frailty business case
- Assumed 2021/22 inflation added for pay (balance of junior doctors' pay award) and non-pay such as increased CNST premium

5.2. **Reserves** have been set centrally for a number of expenditure items, and the intention is that these will be allocated and/or managed as follows:

- **"Winter" Reserve** – a budget has been set which will be utilised to fund the recurrent measures put in place in respect of the emergency village in addition to routine winter requirements. Work is ongoing to firm up the phasing of the release of this reserve which will agreed by DoF and COO.

- **COVID expenditure** - budgets have been developed by reference to actual expenditure patterns in 2020/21 and particularly the post wave 1 expenditure pattern as positive inpatient numbers began to fall. This covers Covid-19 related absence cost, but a number of specific schemes initiated as part of Gold Command arrangements which are currently ongoing. These categories of expenditure will be subject to CBU and Executive Team review of ongoing costs with a view to taking opportunities to reduce the run rate as the year progresses.

- **Run rate in excess of CBU budget** – Whilst the pay budget is set by reference to established posts, there are high levels of vacancies and sickness during Covid-19. This has resulted in expenditure above budget levels being incurred, most notably in Medicine and Emergency Care. Much of this is from premium rate expenditure for medical and nursing back fill. Month 1 reports indicate that large elements of these costs are still being incurred and reducing this run rate will contribute to reducing the financial gap/CIP. The DoF and COO will review these costs with each of the CBUs to agree an action plan to deliver an improvement against the current position.

- **Pressures/developments in 2021/22** – a number of pressures have been identified and have been built into this proposed financial plan. Whilst some of these are unavoidable, a number are still subject to review and prioritisation by the whole Executive Team and provides another opportunity to close the financial gap if these can be reduced in scope.

- **Pay and non-pay inflation** – in addition to funding being allocated into base budgets (5.1 above) a reserve has been set in line with national assumptions for pay and non-pay and is likely to be needed to meet these commitments. The pay inflation reflects two specific two year agreements for junior medical staff and certain A4C staff. However, it should be noted that no national decision on the 2021/22 pay award for staff covered by pay review bodies (Agenda for change staff and senior medical staff). As such this currently excluded from the plan in line with national guidance.

- **Restoration** – HCP guidance is now to include income and costs associated with elective recovery (see income section above) so an expenditure reserve of £1.3 million has been created for H1. The DoF and COO are working with the Planned Care CBU to ensure as much opportunity can be achieved from the Elective Recovery Fund arrangements.

6. Income and Expenditure Plan and Proposed Actions

6.1. Appendix 1 contains the Income & Expenditure plan for H1 and H2 with a downside scenario for H2 subject to further confirmation.

6.2. The 2021/22 plan results in a financial gap of £3.7 million in H1 (£4.5 million initial gap less ERF contribution of £0.8 million), and £7.4m in the full year (£9 million initial gap less ERF contribution of £1.6 million although H2 arrangements not yet confirmed).

6.3. The downside scenario is that NHS Block contract income reduces by a further 3% in H2 resulting in an increased gap of £7.0m in H2, and total gap of £10.7 million for the full year.

6.4. There are four potential ways of mitigating the H1 gap of £3.7 million:

- Productivity improvements – by using marginal increases in cost to deliver additional activity a contribution from the Elective Recovery Fund (in addition to the £0.8m built into the H1 plan)
- Run rate reduction – by avoiding potential expenditure included in the financial plan including Covid/Winter costs c£3.0m and run rates in excess of current budgets £2.9m
- Curtailing planned expenditure – by managing the discretionary investments within the resources available

- Cost Improvement Programme (CIP) – currently identified schemes total £2.5m for the full year, with further work being progressed on CBU schemes.

6.5. It will increase the likelihood of managing within the resources allocated for H1 and the indicative resource for H2 by maximising all four of these opportunities, particularly given the likely increased challenge in H2

7. Cost improvement plan and efficiency

7.1. The following table summarises the current position regarding scheme development of CIP plans as at Friday 21 May. A CBU workshop took place on 20 May to further develop schemes and the total now stands at £2.5m for the full year.

2021.22 CIP Programme			
CBU	**Original Plan**	**Smartsheets Plan**	**RAG**
£'000	*Savings identified through CIP Schemes in Budget Planning and Use of Resources*	*Savings costed to CIP schemes within Smartsheets by Finance Reps*	
Medicines and Emergency Care	£975	£975	
Planned Care	£597	£597	
Specialist Services	£284.5	£284.5	
Corporate*	£0	£0	
Finance	£40	£122.7	
IT	£141.4	£91.5	
Procurement	£374.4	£363.6	
Estates and Facilities	£17.8	£17.8	
Human Resources	£88.3	£14	
Nursing & Midwifery	£0	£46.2	
Medical Director	£0	£0	
Strategy	£17.7	£17.7	
Total	**£2,536.1**	**£2,530.0**	

**Corporate contains a number of budget statements such as CEO, Trust Board, Company Secretary, PR & Comms, Information Governance as well as a "Central Reserves" containing budgets such as CNST, bad debt provisions.*

BRAG	Definition
Blue	Complete
Red	Off track – not recoverable within agreed timescales
Amber	Off track - recoverable
Green	On track

7.2. The movement from "original plan" to "Smartsheets" results from each original scheme going through a validation process and the inclusion of any additional schemes identified.

The RAG status of red and amber indicates that overall, each department is still required to move the schemes from planning into delivery.

8. Capital

8.1. The main source of funding for capital is cash generated from the depreciation of existing assets. This is the easiest capital to obtain as, provided it isn't utilised for other purposes e.g. underpinning a deficit, the Trust already has this cash. The first call on this source of cash is repayment of existing loans, finance lease and PFI principal payments. The most up to date calculation is shown below, with the residual amount available for capital investment.

Internal/approved sources	**21/22 plan**
Planned total depreciation	6,692
Less capital element of payments relating to IFRIC 12/PFI schemes	-750
Less capital element of payments relating to leases	-934
Capital investment loan repayments - principal repayments on new and existing normal loans (approved)	-400
Residual available for capital investment	**4,608**

8.2. Capital is now regionally managed by the Healthcare Partnership (HCP) and an additional £1,033,000 has been agreed in our regionally approved 21/22 plan.

8.3. The total capital allocation for 21/22 is £6,872,000 and is made up of the following:

Funding source	**2021/22**
	£'000s
Internally generated	4,608
PDC	1,033
Donated income	100
IFRIC 12	1,131
	6,872

8.4. The Executive Team have reviewed all strategic priority areas for 21/22 and 22/23 and the plan for utilising the internally generated funds is based on the following values:

- Medical equipment - £0.75m
- Essential Fire works - £1.00m
- Backlog maintenance - £0.75m

- IM&T - £1.00m
- Strategic Schemes - £1.00m

8.5. The budget holders for each of these areas have been asked to identify the priority schemes against these budgets across the two-year financial years, using a risk based approach. The strategic scheme is subject to a business case approval but is expected to be allocated to the implementation of the new medicines management system (EPMA).

8.6. Utilisation of the additional £1,033,000 is going back to the Executive Team for review.

8.7. The Trust can also submit applications for emergency capital, which has to be approved by NHSEI and the HCP. This is funded by additional cash provided to the Trust, if approved. During an earlier data collection, the Trust identified a further £3,116k of critical schemes for 2021/22. There is no guaranteed this capital will be available. Last year this source of capital was not confirmed until July.

8.8. In 2020/21 the Trust was successful in securing a variety of additional sources of capital including A&E capital, endoscopy, and IM&T. The Trust has opportunistically been able to increase its capital allocation by 100% through these routes. Given current national priorities there is likely to be additional capital for restoration (theatres, wards capacity, outpatient and diagnostics) that can be directly attributed to increasing capacity on a cold site. Imaging is likely to be a continuing priority as is IM&T. In 2020/21 the Trust secured an additional c£5m through such sources. However, there are no guarantees this will be available again or how successful our bids will be when the time comes.

9. Conclusion

9.1. Due to the recent notification from the HCP the original financial unmitigated financial gap for H1 has increased from £2.1 million to £3.7 million (note the provisional gap for the full year has increased from £4.2 million to £7.4 million but this is subject to further guidance).

9.2. In order to close the gap, there are a number of initiatives that must be quickly implemented.

9.3. Despite the added financial pressures, we are planning to break-even in both the planning submission to be submitted on 3 June and the Trust's resultant budget.

10. Recommendation

10.1. The Board is asked to approve the setting of a break-even plan for H1 and the indicative for H2 plan (still subject to resource allocation confirmation). This will then form the basis for our final plan submission via the ICS to the NHSEI and budgetary control system.

Southport and Ormskirk Hospital NHS Trust

Appendix 1

	Q1	Q2	Q3	Q4	2021/22
INCOME	**£000**	**£000**	**£000**	**£000**	**£000**
NHS Income	42,183	42,183	42,184	42,184	168,736
Top Up	9,548	9,548	9,439	9,439	37,974
Non NHS Income	1,506	1,506	1,614	1,614	6,240
Education Income	1,458	1,458	1,458	1,458	5,830
COVID	1,945	1,945	1,945	1,945	7,778
Restoration	1,050	1,050	1,050	1,050	4,200
TOTAL INCOME	**57,689**	**57,689**	**57,689**	**57,689**	**230,758**
EXPENDITURE					
Base Budget	**(55,256)**	**(55,256)**	**(55,256)**	**(55,256)**	**(221,024)**
Reserves					
Winter	(556)	(556)	(556)	(556)	(2,222)
COVID	(950)	(950)	(950)	(950)	(3,800)
20/21 Run Rate recognition	(1,438)	(1,438)	(1,438)	(1,438)	(5,752)
Pressures/ developments in 2021/22	(392)	(392)	(392)	(392)	(1,566)
Pay and non pay inflation	(298)	(298)	(298)	(298)	(1,190)
Restoration	(650)	(650)	(650)	(650)	(2,600)
Reserves	**(4,283)**	**(4,283)**	**(4,283)**	**(4,283)**	**(17,130)**
TOTAL EXPENDITURE	**(59,539)**	**(59,539)**	**(59,539)**	**(59,539)**	**(238,154)**
SURPLUS/(DEFICIT) before CIP	**(1,849)**	**(1,849)**	**(1,849)**	**(1,849)**	**(7,396)**
CIP = 1.8%	1,849	1,849	1,849	1,849	7,396
SURPLUS/(DEFICIT) after CIP	**0**	**0**	**0**	**0**	**0**
Downside scenario in H2 with further 3% reduction in resources:					
SURPLUS/(DEFICIT) before CIP	**(1,849)**	**(1,849)**	**(3,500)**	**(3,500)**	**(10,698)**
CIP = H1 3.8%; H2 6.6%	1,849	1,849	3,500	3,500	10,698
SURPLUS/(DEFICIT) after CIP	**0**	**0**	**0**	**0**	**0**

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**02 JUNE 2021**
Agenda Item	**TB097/21b**	**FOI Exempt**	**NO**
Report Title	**MONTH 1 FINANCIAL POSITION 2021/22**		
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 April 2021 (month 1).

Executive Summary

This report provides the financial position at month 1 using the draft plan containing income figures supplied by Cheshire & Merseyside Health and Care Partnership (C&M HCP).

The H1 (1st six months of the year) draft plan had an initial financial gap of £2.1 million.

Since month 1 financial position was declared the HCP have informed us that our planned income figure will now be reduced as part of a system wide redistribution of resources between CCG's and providers. This means:

- H1 planned income will be reduced by £2.4 million.
- The reduction in income will need to be actioned and backdated in month 2. In addition to the reduction in income, we have also been instructed by the HCP to include the forecast financial impact from the Elective Recovery Fund (ERF) in our plans. The contribution is forecast at £0.8 million for H1.
- The result is a further financial challenge of £2.4 million in addition to the draft planned CIP of £2.1 million (total £4.5 million for H1 representing 3.8% CIP).

A surplus of £8,000 has been delivered against the break-even plan which was reported to FP&I Committee on 24 May. The break-even plan relied on the £2.1 million gap in H1 (1st half of the financial year) being mitigated by CIP, underspend against reserves or additional income for activity recovery. This will now increase to £4.5 million gap in H1. April activity is recovering well, particularly in outpatients when compared to the April 2019 performance.

Recommendations

The Board is asked to **note** that:

- Trust has achieved a surplus of £8,000 for month 1.
- Due to a reduction in income of £2.4 million for H1 the "restated" month 1 performance is in the region of £300,000 (£392,000 less ERF contribution of £100,000).

Previously Considered By:

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

Strategic Objectives

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

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

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

Finance Report – Month 1 2021/22

1. Purpose

1.1. This report provides the Board with the financial position for April 2021 (month 1).

2. Executive Summary

2.1. This report provides the financial position at month 1 using the draft plan containing income figures supplied by Cheshire & Merseyside Health and Care Partnership (C&M HCP).

2.2. The H1 (1st six months of the year) draft plan had an initial financial gap of £2.1 million.

2.3. Since month 1 financial position was declared the HCP have informed us that our planned income figure will now be reduced as part of a system wide redistribution of resources between CCG's and providers.

2.4. H1 planned income will be reduced by £2.4 million.

2.5. The reduction in income will need to be actioned and backdated in month 2.

2.6. In addition to the reduction in income, we have also been instructed by the HCP to include the forecast financial impact from the Elective Recovery Fund (ERF) in our plans. The contribution is forecast at £0.8 million for H1.

2.7. The result is a further financial challenge of £2.4 million in addition to the draft planned CIP of £2.1 million (total £4.5 million for H1 representing 3.8% CIP).

2.8. A surplus of £8,000 has been delivered against the break-even plan which was reported to F,P&I Committee on 24 May.

2.9. The break-even plan relied on the £2.1 million gap in H1 (1st half of the financial year) being mitigated by CIP, underspend against reserves or additional income for activity recovery. This will now increase to £4.5 million gap in H1.

2.10. April activity is recovering well, particularly in outpatients when compared to the April 2019 performance.

3. Income & Expenditure for Month 1

3.1. The following table illustrates performance to date for month 1:

I&E (Including R&D)	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Commissioning Income	182,030	15,193	15,192	(1)	15,193	15,192	(1)
PP, Overseas & RTA	616	51	53	2	51	53	2
Other Income	10,100	856	791	(65)	856	791	(65)
NHSE/I Top up	38,193	3,183	3,183	(0)	3,183	3,183	(0)
Total Operating Income	**230,939**	**19,283**	**19,218**	**(65)**	**19,283**	**19,218**	**(65)**
PAY	(161,516)	(13,480)	(13,558)	(79)	(13,480)	(13,558)	(78)
NON PAY	(65,404)	(5,468)	(5,337)	132	(5,468)	(5,337)	131
Total Operating Expenditure	**(226,920)**	**(18,948)**	**(18,895)**	**53**	**(18,948)**	**(18,895)**	**53**
Operating surplus/deficit	**4,019**	**335**	**323**	**(12)**	**335**	**323**	**(12)**
NET FINANCE COSTS	(4,019)	(335)	(331)	4	(335)	(331)	4
Retained Surplus/Deficit	**0**	**0**	**(8)**	**(8)**	**0**	**(8)**	**(8)**
Technical Adjustments	0	0	17	17	0	17	17
Break Even Surplus/(Deficit)	**0**	**0**	**8**	**8**	**0**	**8**	**8**
Impact of proposed amendment to Financial Plan and Budget following C&M HCP communication on 21 May 2021:							
NHSE/I Top Up	*(4,800)*	*(400)*	*(400)*	*0*	*(400)*	*(400)*	*0*
Expenditure reductions	*4,800*	*400*	*0*	*400*	*400*	*0*	*400*
Break Even Surplus/(Deficit)	***0***	***0***	***(392)***	***(392)***	***0***	***(392)***	***(392)***

3.2. The opening annual budget is the H1 (1st half of the year) plan submitted to NHSEI on 5 May multiplied by a factor of two.

3.3. The opening annual budget has been profiled equally across 12 months.

3.4. The Trust has delivered a surplus of £8,000 surplus against the break-even plan for month 1.

3.5. However, as a result of a late change by the HCP to reduce Trust income (after the closedown of month 1), the table above in italics illustrates the financial impact on month 1 performance. The £8,000 surplus would be replaced by a revised deficit of £392,000 due to the reduction in income. Note that this excludes any contribution from the Elective Recovery Fund (ERF) which could result in £100,000 improvement on the £392,000 deficit (section 5 below).

3.6. Note the remainder of this report refers to the financial performance before the HCP £2.4 million income adjustment was communicated.

3.7. The main issue of note is that expenditure has been contained within the resources available in month 1.

3.8. A pressure is emerging in income relating to continued shortfalls in catering and car park income and other marginal income losses which will be reviewed in month 2.

3.9. Pay expenditure is overspent but this is mainly due to the maintenance of COVID measures into month 1 which is higher than the budget which is profiled in twelfths.

3.10. COVID expenditure of £397,000 has been incurred against a budget of £316,000 (H1 plan of £1.9 million divided by 6). We anticipate a reduction in COVID expenditure in the coming months due to the very small number of positive patients being admitted. COVID expenditure has reduced significantly since March but needs to reduce much further in future months, particularly in view of the reduction in income described in section 3.5.

3.11. Non Pay expenditure is underspent due to drugs (Specialist and Medicine & Emergency Care CBU's) and medical and surgical equipment in Planned Care. Note the non pay budget is based on 2019/20 outturn plus inflation so will underspend if activity levels have not fully returned.

4. Business Unit Budget Performance

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

	Annual	Year to Date			In Month - Month 1		
Business Unit	Budget	Budget	Actual	Var	Budget	Actual	Var
	£000	£000	£000	£000	£000	£000	£000
Medicine & Emergency Care	(55,587)	(4,632)	(5,271)	(639)	(4,632)	(5,271)	(639)
Planned Care	(58,504)	(4,875)	(4,717)	158	(4,875)	(4,717)	158
Specialist Care	(42,164)	(3,513)	(3,403)	110	(3,513)	(3,403)	110
Corporate	201,932	16,851	17,564	713	16,851	17,564	712
Finance	(6,770)	(564)	(548)	16	(564)	(548)	16
Estates & Facilities	(16,845)	(1,404)	(1,395)	9	(1,404)	(1,395)	9
Human Resources	(3,121)	(260)	(249)	11	(260)	(249)	11
Nursing & Midwifery	(3,733)	(311)	(375)	(64)	(311)	(375)	(64)
Medical Director	(9,019)	(752)	(748)	4	(752)	(748)	4
Strategy	(2,170)	(205)	(519)	(314)	(205)	(519)	(314)
Financing Costs	(4,019)	(335)	(331)	4	(335)	(331)	4
Total	**0**	**0**	**8**	**8**	**0**	**8**	**8**

4.2. Whilst analysing performance in the above table it is important to remember that no reserves have been allocated into business units in month 1. All reserves remain within Corporate.

4.3. Medicine & Emergency Care's budget in the above table does not include any allocation from reserves. The CBU's adverse variance is mainly driven by the premium rate expenditure (bank and agency spend in month 1 is £1.3 million). Even after the allocation of reserves the CBU is expected to be adverse to budget.

4.4. We have initiated a specific session with Medicine & Emergency Care CBU to review their pay expenditure from 19/20 in order to determine whether it is reasonable to continue those investments.

4.5. Corporate contains the reserves which will only be allocated from month 2 onwards once they have been prioritised by the Executive Team taking into account the robustness of the CIP Programme.

4.6. Both Planned Care (eg T&O, Urology, Ophthalmology) and Specialist Care (eg Paediatrics) are underspending due to services not yet fully restored to 2019/20 activity levels.

4.7. Nursing & Midwifery adverse variance relates mainly to international nurse recruitment costs which do not yet have a budget allocated from reserves.

4.8. Strategy adverse variance relates solely to COVID expenditure which does not yet have a budget allocated from reserves.

5. Activity Performance and Elective Recovery Fund (ERF)

5.1. 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																										2021/22	
	Average		Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Oct-20		Nov-20		Dec-20		Jan-21		Feb-21		Mar-21		Apr-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	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	798	6,590	975	7,146	1,050
DC	1,701	912	436	195	453	206	657	348	1,050	550	1,051	550	1,314	747	1,338	746	1,305	749	1,178	626	932	444	982	471	1,220	585	1,188	590
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	1,899	187	1,961	193	1,876	187
EL	175	504	32	93	41	110	44	89	91	235	111	296	124	337	174	437	163	380	134	399	90	180	68	153	104	244	118	302
NEL	2,838	5,358	1,626	2,546	2,053	3,285	2,223	3,934	2,287	4,667	2,094	4,340	2,201	4,546	1,952	3,921	2,060	4,083	2,012	4,489	1,832	3,812	1,930	3,628	2,503	4,277	2,563	5,370
OP F2F	10,196	1,151	2,275	269	2,505	311	3,767	448	5,891	680	5,989	695	7,757	898	8,077	909	7,699	893	7,121	814	6,562	758	6,643	764	7,964	918	7,167	838
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	7,449	433	6,577	375	6,710	392	6,579	388	7,161	430	6,453	500
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	3,139	445	3,993	568	3,361	457
Grand Total	29,866	9,939	15,234	4,256	17,868	5,343	23,872	6,692	28,167	8,202	25,759	7,812	30,010	8,649	29,118	8,032	29,254	8,137	26,968	8,224	25,493	7,022	25,815	6,832	31,496	8,190	29,872	9,294

5.2. The Trust continues to show an improvement in elective performance in April 2021, with day cases maintaining at 70% of the 2019/20 average after the initial increase to 72% in March and elective cases increasing from 59% in March to 67% in April 2021.

5.3. The table below illustrates month 1 performance against a number of measures:

PbR Activity & Income									
	2019/20 Average		2019/20 Apr-19		2020/21 Apr-20		2021/22 Apr-21		Apr-21 V Apr-19
POD Summary	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual	PbR Income £'000	Activity Actual %
A&E	7,284	1,166	7,176	1,158	3,404	611	7,146	1,050	99.6%
DC	1,701	912	1,707	945	436	195	1,188	590	69.6%
DI	1,862	179	1,729	166	551	51	1,876	187	108.5%
EL	175	504	144	444	32	93	118	302	81.9%
NEL	2,838	5,358	2,635	5,237	1,626	2,546	2,563	5,370	97.3%
OP F2F	10,196	1,151	10,342	1,168	2,275	269	7,167	838	69.3%
OP NF2F	1,148	36	796	25	6,180	374	6,453	500	810.7%
OPPROC	4,662	633	4,732	640	730	118	3,361	457	71.0%
Grand Total	**29,866**	**9,939**	**29,261**	**9,783**	**15,234**	**4,256**	**29,872**	**9,294**	

5.4. With the reduction in the COVID numbers across the Cheshire and Mersey Region, the move is now to restore the Elective activity. The Elective Recovery Fund (ERF) will be paid retrospectively based on how the Region performs against the notified baselines based on 2019/20 activity.

5.5. The Trust's target activity is set at 70% for April 2021. The right hand column in the table above shows the performance compared to April 2019. We understand this is the measure that will be used by to allocate ERF but any future income will also be linked to the system performance.

5.6. Diagnostic Imaging performance is 101% in month against last year's average and this year's target for February 2021 of 90%.

5.7. 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 47% of all contacts.

5.8. Both A&E attendances and non-elective admissions observed a continued increase in April 2021 first shown in March 2021 returning close to 2019/20 levels.

5.9. We estimate that there may be a contribution of £0.8 million from ERF in H1. Although no benefit has been recognised in month 1 until figures are confirmed we estimate that there

could be a contribution in the region of £100,000.

6. Cash

6.1. The cash balance at the end of April was £7.2 million.

6.2. This was slightly above the forecast of £6.8 million given to Committee last month.

6.3. Note after discussions with the national team and corrections, the Trust's final position for 20/21 against its External Financing Limit (EFL) was an undershoot of £79,000.

6.4. For H1 there's unlikely to be any requirement for the Trust to borrow money for working capital.

7. Debtors

7.1. Overall debt has reduced from £4.8 million last month to £4.4 million this month.

7.2. The change is split as an increase of £0.1m on non NHS debt and a decrease of £0.5m on NHS.

7.3. An action plan is being worked on to reduce this level of debt which is currently running at just over £1m.

8. Recommendation

8.1. Board to note

- Trust has achieved a surplus of £8,000 for month 1.
- Due to a reduction in income of £2.4 million for H1 the "restated" month 1 performance is in the region of £300,000 (£392,000 less ERF contribution of £100,000).

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

Committee/Group Meeting date:	Workforce Committee 25 May 2021
Lead:	Pauline Gibson

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence
The sickness absence rate overall has increased to 6% in month against the newly revised target of 5%. The HR Business Services team are proactive in their attempts to reduce this figure. The CBUs have created improvement trajectories and there is a dedicated HR Advisor to support each CBU. A full sickness absence presentation on the approach to reduce this metric will be provided to the Committee in June 2021.

ADVISE

PDRs
Compliance for PDRs has increased by 4.3% in May 2021. The HR team are currently focussing solely on compliance to comply with the organisation's responsibilities, before starting any improvement work. The CBUs have created their own improvement trajectories.

Medical and Nursing Vacancies
Medical and Nursing vacancies are showing sustained statistical improvements with a strong pipeline. 44 out of 45 nurses have passed their OSCE which is a huge achievement and the efforts of all involved were recognised by the Committee. The current pause in relocation from India will delay nurse projections and work is underway to mitigate this and the retiring workforce profile we have. In addition, the Resourcing teams plan to review an approach to international medical recruitment.

Staff Turnover
Staff turnover has increased in month. The target for this metric has now been aligned to Model Hospital data and NHS Digital data. The rolling figure is impacted by August 2020 spike and another spike will come next month on completion of the paid student placements. Flexible rostering is being explored as a retention tool to mitigate some of the turnover.

Bank and Agency staff costs
Significant progress has been made converting from agency to bank. The costs for bank and agency within the organisation are continuing to decrease based on a decrease of fill and/or usage and returning shielders are positively impacting this metric. Ongoing improvements are expected in the level of spend.

Undergraduate Deans Visit – July 2021
The Medical Director attended the meeting to provide an update on the Dean's visit in July 2021. Actions from the 2020 visit are in progress and the Executives were confident that the action plan will be produced and completed before the visit.

ASSURE

Mandatory Training
Whilst Mandatory Training compliance has slightly decreased in month, it is still reaching the 85% target for compliance. There is focussed support on this.

Safe Staffing
The Trust reports safe staffing in month at 92.5% against the national target of 90%.

Time to Hire
The time to hire increased to 56.16 days in month. whilst disappointing, it was entirely related to consultant notice periods. The Chair requested additional reporting that removes metrics which are beyond the control of the Trust, to ascertain how the Trust are performing.

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

Workforce

Organisational Development

Analyst Narrative:

The target for Personal Development Reviews has been amended to 85% in line with Model Hospital National Median. Whilst this indicator continues to fail its assurance measure, there has been a 4.3% increase in April. Mandatory training is currently assured but is showing special cause concern in month with a further decline. This requires further narrative.

Operational Narrative:

Mandatory training remains above the 85% target at 85.1%, but has shown a decline in month of 0.027%. The main areas of concern are conflict resolution and moving & handling training which have shown a 1.15% and 1.80% drop in month respectively. In the absence of subject matter experts to train the courses, there are interim measures in place for staff to update the training online. The Training Department is working with the Trust's Health & Safety Lead to look for external provision to resolve the issue until substantive arrangements can be made the H&S department.

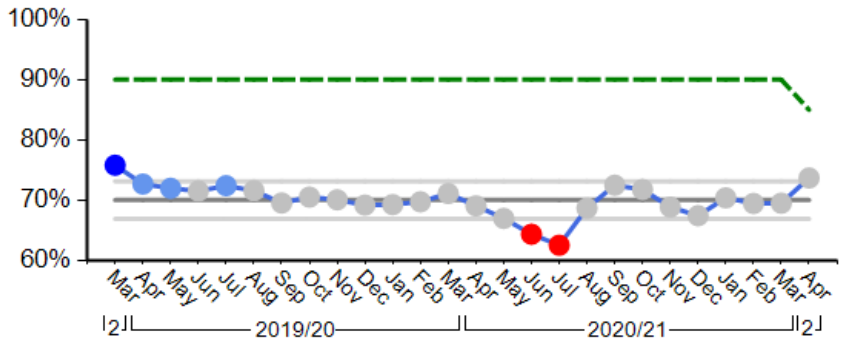
All core mandatory training subjects can be updated online via ESR with the exception of Resuscitation Training for which there is a full programme of training available. To assist managers to release staff to update training online, the Training Department is scheduling a series of events to support staff: 1-1 online or face to face sessions or bookable computers spaces at either site with support on hand if requested. This support is to assist managers and staff to roster training in to their rotas.

New starters have access to update core mandatory training as part of our streamlining process, this is not mandated. New starters then have 4 weeks within which to update all core mandatory training online. To monitor this, the Training Department is working with the BI Team to establish a new starter compliance report which will be circulated monthly along with the monthly suite of reports to flag to new staff and their line managers where there are gaps. The Training Department continue to contact all new starters once appointed to remind them of their responsibilities.

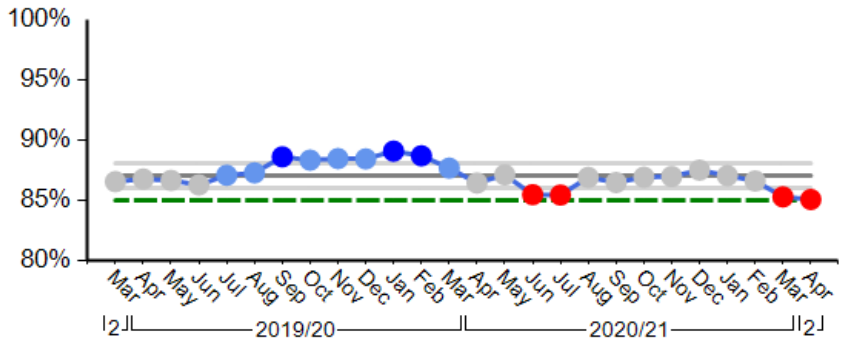
The action plan relating to Personal Development Reviews has been updated and is included.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	73.7%	N/A	Apr 21		90%	69.5%	Mar 21	85%	73.7%	
Mandatory Training	85%	85.1%	N/A	Apr 21		85%	85.3%	Mar 21	85%	85.1%	
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%	

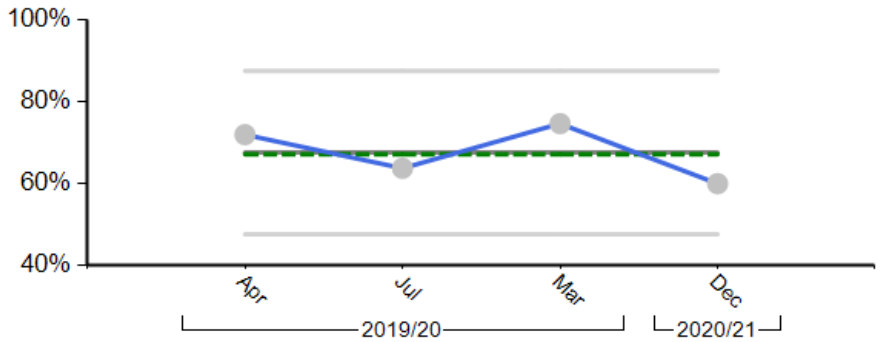
Personal Development Review



Mandatory Training



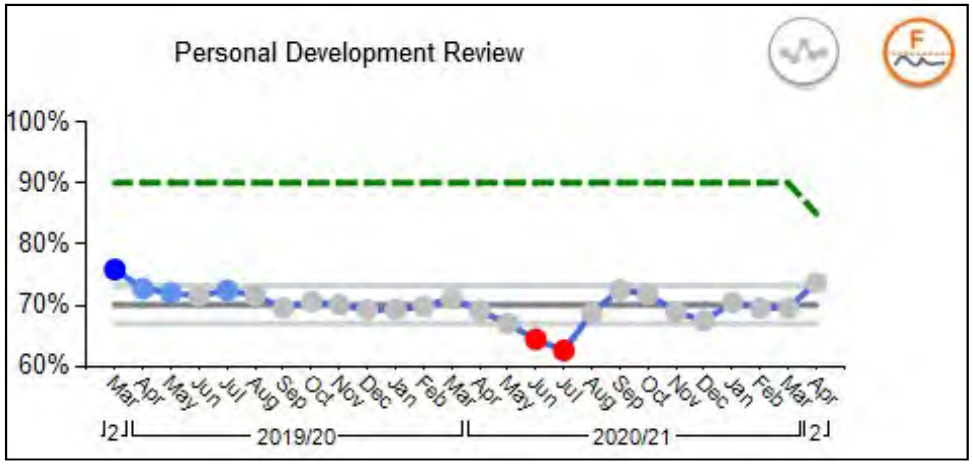
Friends and Family Test - Staff - % That Would Recommend As Place To Work - Trust Overall



Non Medical Appraisal/Personal Development Reviews

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Personal Development Review	85%	73.7%	N/A	Apr 21		90%	69.5%	Mar 21	85%	73.7%	



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 an 85% 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 85% target. There is a second stretch target f 90%. Throughout April there has been increased focus on compliance with CBU's and Departments asked for trajectories to meet the target by end of August. An updated Action Plan and associated activity has refocused efforts, resulting in a 4.22% increase at the end of April.

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 late Autumn 2021, the Trust should expect

- All data reviewed in ESR to support accurate reporting information and a steady increase in compliance rates
- 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

PDR project focused on improvements for the coming year commenced during May through to late Autumn

Workforce

Sickness, Vacancy and Turnover

Analyst Narrative:

The targets within this section have been updated in line with the benchmarking data obtained from Model Hospital or NHS Digital.
Several indicators within this section are failing their assurance measure. These relate to sickness, vacancies and turnover. The in-month sickness rate is showing special cause concern and has increased marginally in April, impacted by increases in both Registered and Non-Registered Nurse Sickness. Despite a slight increase in medical vacancies in month, both medical and nurse vacancy rates are showing special cause improvement due to sustained improvements.

Operational Narrative:

During April both nursing and Medical vacancies have remained static, however we have a strong pipeline for both. For medical vacancies we currently have 16 posts under offer, including some notable successes in having offers accepted for Radiology Consultants. We are continuing to work with agencies to source candidates for our difficult to fill roles with some good results.

Our nursing picture is static, however we had 11 nurses pass their OSCE late in April and these will move into their band 5 posts shortly. The current pause in relocation from India will delay our projections for nurses, but we are working with NHSP and the Collaborative recruitment hub to ensure we have plans in place to mitigate some of these delays. Whilst we have had a key focus on international recruitment it is noted that the nursing team have still been working hard to ensure we retain our students that undergoing training with us and in July we will be welcoming the students into the numbers.

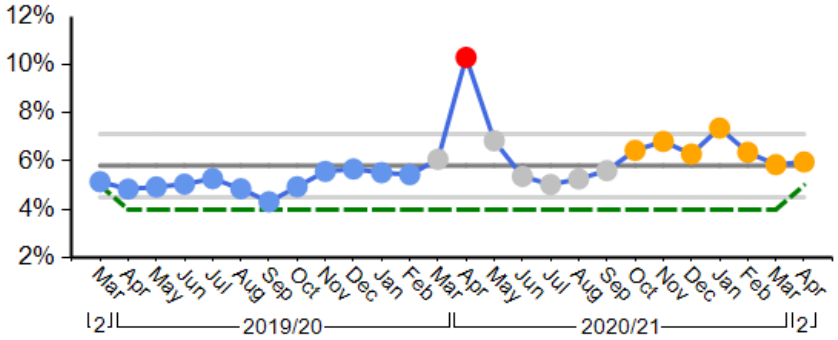
There has been some concern in respect of the AHP vacancy rate, but work has been ongoing to ensure that we improve this position and at present we have 15 posts under offer with a further 14 advertised, which is reflective of the vacancy position and will ensure that this also improves.

Turnover is slightly above target, but this is due to a significant number of retirements in month and we are continuing to look for ways to retain staff. The rolling figure is still impacted by the spike in August 2020 and there will be a further spike next month following the completion of the paid placements for the student nurses, who did a 10 week contract at band 4 level.

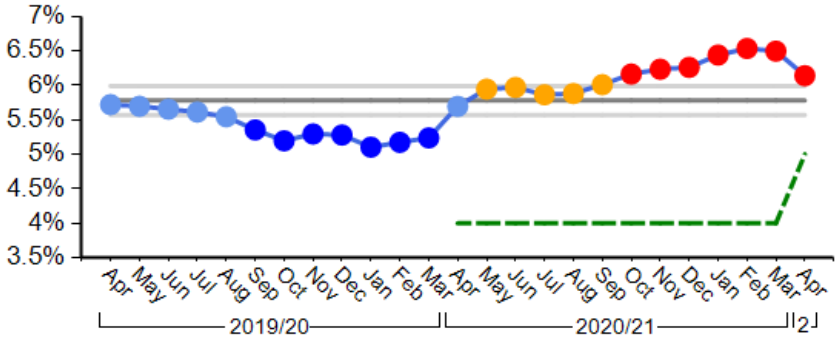
Please see also supplementary action plan relating to sickness absence.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	5%	6%	N/A	Apr 21		4%	5.9%	Mar 21	5%	6%	
Sickness Rate (Rolling 12 Month)	5%	6.1%	N/A	Apr 21		4%	6.5%	Mar 21	5%	6.1%	
Sickness Rate - Medical Staff	5%	2.4%	N/A	Apr 21		4%	2.7%	Mar 21	5%	2.4%	
Sickness Rate - Nursing Staff	5%	7.9%	N/A	Apr 21		3.7%	7.3%	Mar 21	5%	7.9%	
Sickness Rate (not related to Covid 19) - Trust		5.4%	N/A	Apr 21			5%	Mar 21		5.4%	
Trust Vacancy Rate – All Staff	6.8%	8.6%	N/A	Apr 21		6.8%	8.5%	Mar 21	6.8%	8.6%	
Vacancy Rate - Medical	7.4%	8.5%	N/A	Apr 21		5%	7.7%	Mar 21	7.4%		
Vacancy Rate - Nursing	9%	9%	N/A	Apr 21		9%	9%	Mar 21	9%		
Staff Turnover	0.75%	1%	N/A	Apr 21		0.8%	0.9%	Mar 21	9%	6.8%	
Staff Turnover (Rolling)	10%	13.8%	N/A	Apr 21		10%	13.4%	Mar 21			
Staff Turnover - Nursing	0.8%	0.7%	N/A	Apr 21		0.7%	1%	Mar 21	9.6%	0.7%	
Time to Recruit	55	58	N/A	Apr 21		55	52	Mar 21	55	58	

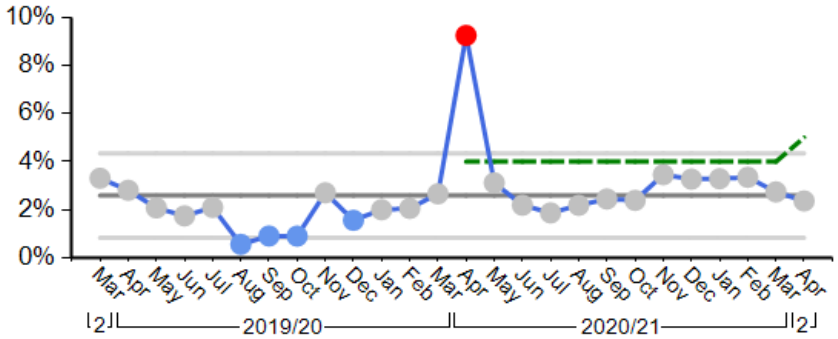
Sickness Rate



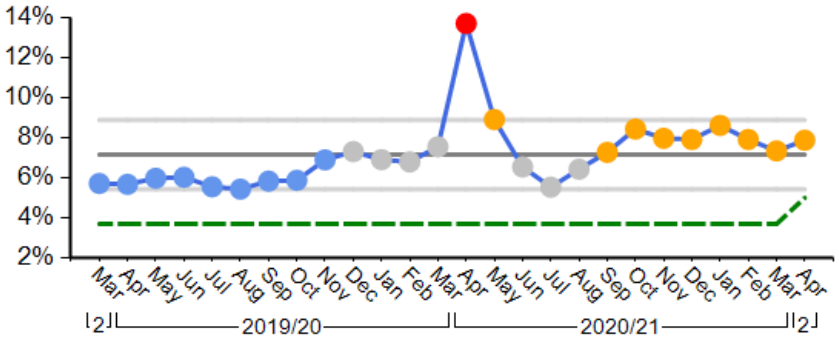
Sickness Rate (Rolling 12 Month)



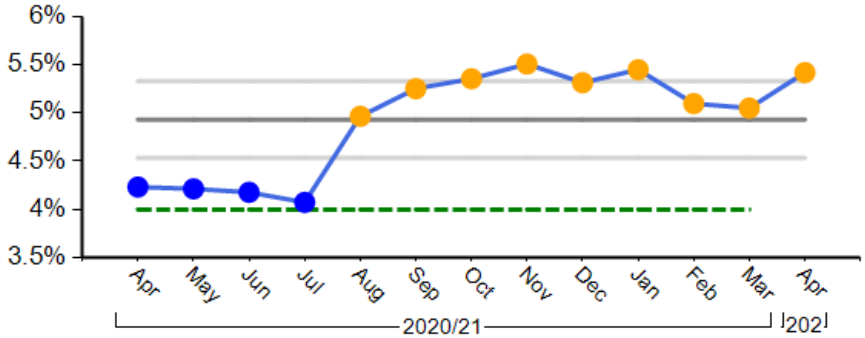
Sickness Rate - Medical Staff



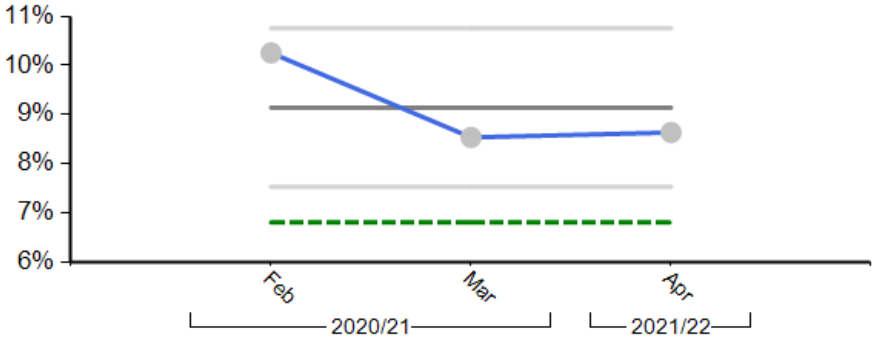
Sickness Rate - Nursing Staff



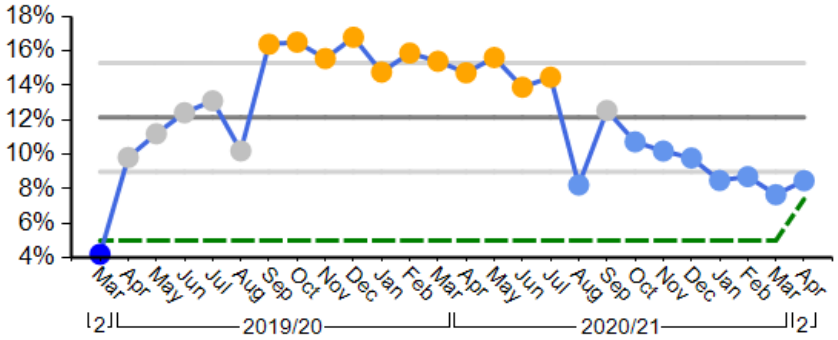
Sickness Rate (not related to Covid 19) - Trust



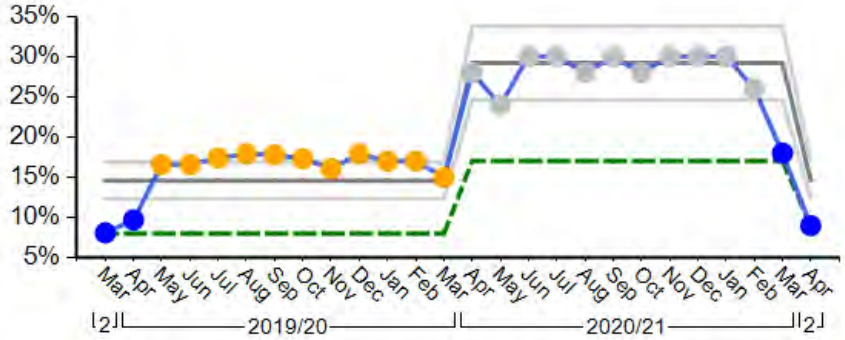
Trust Vacancy Rate – All Staff



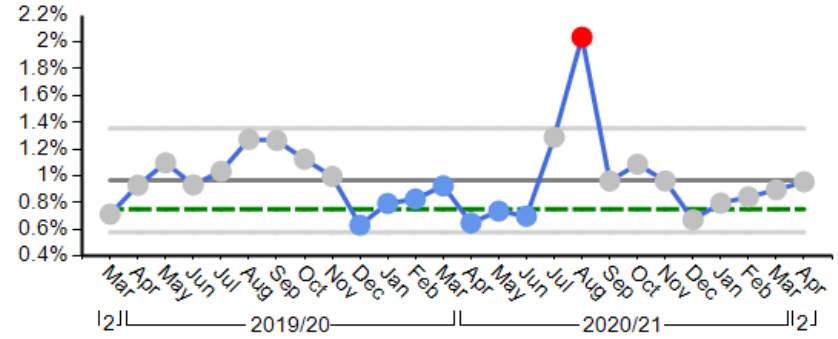
Vacancy Rate - Medical



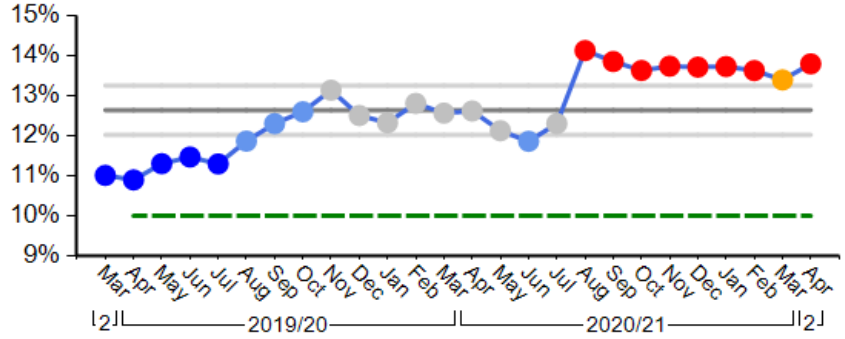
Vacancy Rate - Nursing



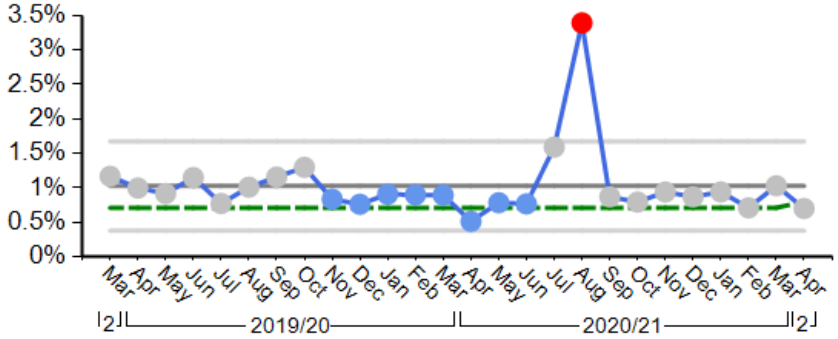
Staff Turnover



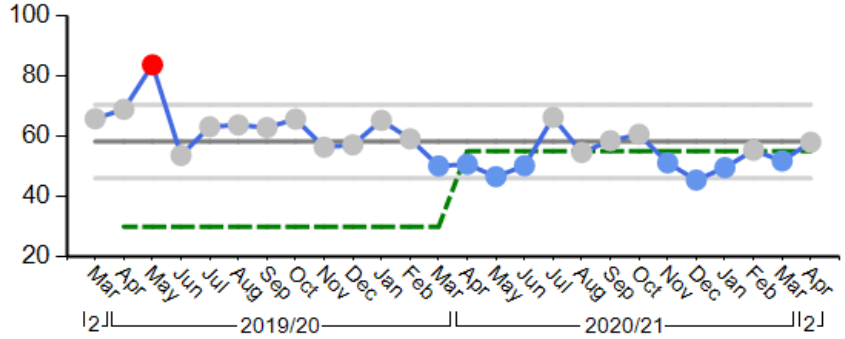
Staff Turnover (Rolling)



Staff Turnover - Nursing



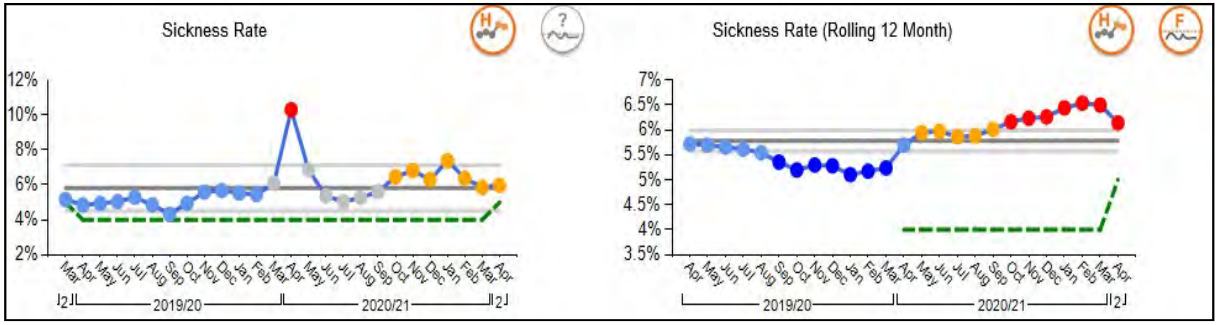
Time to Recruit



Sickness Absence

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness Rate	5%	6%	N/A	Apr 21	H	4%	5.9%	Mar 21	5%	6%	?
Sickness Rate (Rolling 12 Month)	5%	6.1%	N/A	Apr 21	H	4%	6.5%	Mar 21	5%	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: We are in a 'recovery and reset' phase, so whilst improvement may be slow, we also need to be looking to secure sustainable improvements with the actions we are taking. The special leave and flexible working policies will also be reviewed to support attendance at work by reducing potential for 'burn out' and more flexibility to manage work/life balance. A slight increase in April as we continue to focus on the longest term absences proactively moving them along in line with policy.

Issues:

Prompt recording of absence data and use of information to inform actions to support attendance

Some duplicate recording occurring and work in ongoing to establish solutions for the future

E-Rostering not rolled out to all departments yet—eg Estates and Facilities

Staff unaware of the impact of their absence on the Trust overall

Actions:

- Flexible and targeted support for managers inc. 'How to' guides , HR drop in clinics and bitesize sessions on key topics
- Review of special leave and flexible working policies
- Staff engagement and communication plan focussing on the 'hearts and minds'
- Review of practice relating to shift allocations and effective management of annual leave

Mitigations:

MIAA Audit undertaken October 2020