Southport and Ormskirk Hospital NHS Trust

AGENDA
BOARD OF DIRECTORS' MEETING
To be held at 0900 on Wednesday 07 July 2021

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
TB103/21 (V)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*DoN*	10 mins
TB104/21 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB105/21 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB106/21 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 02 June 2021.*	No	*Chair*	5 mins
TB107/21 (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				**0915**
TB108/21 (V)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*5 mins*
TB109/21 (D)	**Chief Executive's Report** *Purpose: To **receive** an update on key issues from the CEO*	*No*	*CEO*	*10 mins*
RISK AND GOVERNANCE				**0930**
TB110/21 (D)	**Audit Committee AAA Highlight Report** *Purpose: To **receive** the Audit Committee AAA Highlight Report for assurance*	*No*	*Cttee Chair*	5 mins

TB111/21 (D)	**Board Assurance Framework** *Purpose: To **receive** the updated Board Assurance Framework*	*No*	*ADCG*	5 mins
TB113/20	**Corporate Governance Policies** a) Standing Orders b) Scheme of Reservation and Delegation c) Standing Financial Instructions *Purpose: To **approve** the Corporate Governance Policies*	*No*	*ADCG*	10 mins
INTEGRATED PERFORMANCE				**0955**
TB114/21 (D)	**Integrated Performance Report (IPR) Summary** *Purpose: To **note** the IPR for assurance.*	*No*		
WORFORCE COMMITTEE				**0955**
TB115/21 (D)	**Workforce Reports** a) Committee AAA Highlight Report *b)* Workforce Performance Report *c)* Our People Plan – Progress Update *Purpose: To **receive** the reports for information and assurance.*	*No*	*Cttee Chair* *DoHR* *MD*	15 Mins
OPERATIONS AND FINANCE				**1010**
TB116/21 (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
TB117/21 (D)	**Finance Reports** *a)* Month 2 Financial Position *Purpose: To **note** the Month 2 Financial Position*	*No*	*DoF*	5 mins
QUALITY & SAFETY				**1030**
TB118/21 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report 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*	*No*	*Cttee Chair* *DoN/MD*	15 mins

TB119/21 (D)	**Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme Report** *Purpose: To **receive** and **approve** the CNST Report*	*No*	*DoN*	5 mins
TB120/21 (D)	**CQC Progress Report** *Purpose: To **note** the CQC Progress Report*	*No*	*DoN*	10 mins
TB121/21 (D)	**Update on Orthopaedics Service** *Purpose: To **receive** an update on Orthopaedics Service*	*No*	*MD*	10 mins
ITEMS FOR INFORMATION				**1050**
TB122/21 (D)	**Annual Reports endorsed by Quality and Safety Committee** a) Infection Prevention and Control Annual Report b) Health and Safety Annual Report c) Patient Experience Annual Report *Purpose: To **receive** and **note** the Annual Reports*	No	MD DoN	
CONCLUDING BUSINESS				**1050**
TB124/21 (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*
TB125/21 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*		*Chair*	*5 mins*
TB12621 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	
	Date and time of next meeting: **10.00** Wednesday 01 September 2021			***1100 close***
RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC				
	The Trust Board resolves that representatives of the press and other members of the public be excluded from the		**Chair**	

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.

Board of Directors Register of Interests
as at 01 July 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
CLARK, Dr Kate	Medical Director	Yes	Secondary Care Clinician Governing Body Member for Trafford CCG Director of TechPanda	Nil	Nil	Nil	07-Jun-21
CRAIG, Mr Ian	Non-Executive Director Designate	Yes	Trustee at Willowbrook Hopsital, St Helen's and The Brain Charity, Liverpool				01-Jun-21
GIBSON, Mrs Pauline	Non-Executive Director	Yes	Director: Excel Coaching and Consultancy	Nil	Nil	Nil	28-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

Board of Directors Register of Interests
as at 01 July 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
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
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
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 02 June 2021
(Subject to the approval of the Board on 07 July 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
Dr Kate Clark	Medical Director *(Part 2)*
Mrs Pauline Gibson	Non-Executive Director
Dr Terry Hankin	Medical Director
Ms Bridget Lees	Director of Nursing, Midwifery and Therapies
Mr John McLuckie	Director of Finance
Mr Gurpreet Singh	Non-Executive Director
Mr Steve Shanahan	Director of Finance *(Part 1)*

In Attendance

Rev Martin Abrams	Hospital Chaplain and Freedom to Speak Up Guardian *(Item TB0095/21)*
Ms Lynne Barnes	Interim Deputy Director of Nursing *(Item TB083/21)*
Miss Lynne Eastham	Associate Director of Midwifery, Nursing & AHPs *(Item TB094/21)*
Mr Tony Ellis	Communications and Marketing Manager
Mrs Uma Karthikeyan	Clinical Director Obstetrics & Gynaecology *(Item TB094/21)*
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Chrisella Morgan	Deputy Chief Operating Officer *(Part 1)*
Mrs Lesley Neary	Chief Operating Officer
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

Apologies

Mr Graham Pollard	Non-Executive Director

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB083/21	**Patient Story** *(Ms Barnes joined the meeting)* Ms Barnes introduced the Patient Story which addressed a request by the Board to evaluate the impact of screens on the communication and isolation of elderly patients. The story sought to gain a view on a patient's experience during Covid-19. Mr Moffett relayed his experience as an inpatient within the Trust during Covid-19. He advised that overall, he had been impressed by the hospital and the steps taken to ensure that patients were kept safe during the pandemic which included the installation of screens which made it easier for cleaning.	

Ms Barnes advised that the Senior Nursing Team had spoken to 27 patients during their recent walkabout and there had been an overwhelming sense that the patients had felt safe and understood the measures that were in place to protect them and the staff. One of the patients had commented that she had found it difficult to communicate due to a hearing impairment and relied on lip reading to communicate. Ms Barnes advised that since this conversation listening devices had been provided for the patients.

The Trust would like to reintroduce hospital visiting and, in line with the national guidelines, had devised a plan and visiting would be reintroduced on the Spinal Injuries Unit (SIU), Rehab and Intensive Care Unit (ICU). Safety measures, which included lateral flow tests, track and trace, temperature checks and personal protective equipment (PPE) would be introduced.

Mr Masom commented on the positive feedback received from Mr Moffett.

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

(Ms Barnes left the meeting)

TB084/21 Chair's welcome and note of apologies

Mr Masom welcomed all in attendance and in particular welcomed Mr McLuckie and Mrs Neary to their first Board meeting.

He welcomed members of the public to the meeting and reminded everyone present that this was a meeting held in public and that only pre-lodged questions or comments would be tabled.

The Board noted apologies for absence from Mr Pollard.

TB085/21 Declaration of interests

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

TB086/21 Minutes of the previous meetings

The Board reviewed the minutes of the meeting held on 05 May 2021 and approved them as a correct and accurate record of proceedings subject to the following amendments:

- TB066/21 – to be amended to 'easier in that we faced an existential crisis and there was a national response to Covid-19'
- TB077/21 – to be amended to 'Audit Committee and Assurance Committees'

RESOLVED:
The Board **approved** the minutes from the meeting held on 05 May 2021.

TB087/21 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

TB087/21 Chair's Report

Mr Masom presented his report which detailed the activities undertaken since the previous meeting. He thanked all staff for their hard work which was evidenced by the report from the unannounced Care Quality Commission (CQC) visit in March which had attracted interest in the local media.

With regards to changes in Board membership, Mr Masom highlighted that this was the last Board meeting for Dr Hankin and Mr Shanahan who were retiring from the Trust in June. He led the Board in thanking Dr Hankin for his contribution to the improvement in mortality rates, and Mr Shanahan for overseeing a significant underlying financial deficit during his five years with the Trust.

The recruitment process for an Associate Non-Executive Director had been completed and Mr Ian Craig had been appointed to the post from 01 June 2021.

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

TB088/21 Chief Executive's Report

Mrs Armstrong-Child presented her report which provided an overview of activities that had occurred within the Trust. It was noted that the following awards had been presented to recipients in May in recognition of the work that they had undertaken:

- SO Proud Awards were handed to Kim Lucey, Louise Lancaster, Heidi Moran, Lesley Brant, Kathryn Mullen, Michaela Hadwin, Dawn Nicholson, Jo Forshaw and Erica Isherwood
- Thanks a Bunch Awards had been awarded Ward 10a (Acute Medical Unit), Ward 7B (Rehab) and the Discharge Lounge.
- Care Certificates had been awarded to Peter Bryan, Chris Butler, Carol Smith, Hayley Cook and Dermot Furlong.

- The Neonatal Team had secured a UNICEF UK Baby Friendly accreditation.

Mrs Armstrong-Child provided an overview of her report and outlined the following key points:

- the importance of recognising the improving picture and continued focus on maintaining and improving standards following receipt of the CQC report.
- Whilst initial focus had been on vaccinating staff, 20,000 vaccines had now been administered to the wider health and care colleagues. In addition, the work to review the remaining 8% who had not received their vaccines had now been concluded. The main reasons for staff declining the vaccinations included pregnancy, continuing illness whilst some cited personal reasons. An extra clinic had now been arranged for those staff who had advised that they required a vaccination.
- With the exception of one candidate, all 45 nurses from the international cohort that had sat the Objective Structured Clinical Examination (OSCE) exam, which was a requirement to apply to practise as a registered nurse, had passed.
- Visiting arrangements remained a subject of concern and was regularly discussed within the Trust, at Gold Command meetings and within the wider system. The current Hospital visiting policy was under review in conjunction with trusts across the Cheshire and Mersey (C&M) region to ensure that visiting was equitable across all hospitals.
- The Trust was in receipt of a Regulation 28 report to prevent other deaths, issued by the HM Coroner following an inquest in Liverpool. The Trust was in the process of reviewing the referral processes and communication would be provided to the Coroner by 3 July.

In response to Mr Masom's question around having a plan for car parking once visitors were allowed back on-site Mrs Armstrong-Child advised that the current process would be reviewed.

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

INTEGRATED PERFORMANCE

TB090/21 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 April 2021. In response to Mrs Morgan's request for feedback on the amended format of the report, Mrs Gibson requested the inclusion of Strategic Objective (SO) 5 within the summary.

QUALITY AND SAFETY

TB091/21 Quality and Safety Reports

a) Committee Highlight Report

Dr Bricknell presented the report following the Quality and Safety Committee meeting held on 24 May 2021 and highlighted that there were no alerts to escalate to the Board. The Committee advised that:

- Progress on lost to follow up patients had been noted at the meeting given the ongoing work internally and support from commissioners.
- The external orthopaedic review was expected to be presented at Board next month following receipt of the report from the Royal College. A copy of the report would be shared with external agencies.

Mr Birrell welcomed the introduction of the Discharge with Dignity initiative within the Trust which had been introduced to ensure that 15 minutes was allocated for final checks prior to discharge. Ms Lees advised that this undertaking would remain a priority 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 provided assurance that the increase in Clostridium Difficile (C.Diff) was not related in terms of time or location and further advised that external expertise had been requested.

It was noted that there had been a decline in the Family and Friends response rate, and this would be discussed at the Quality and Safety Committee (QSC).

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

c) Summary Report of Changes to Infection Prevention and Control Assurance Framework

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

RESOLVED:
The Board **noted** the progress in relation to measures within the IPC Board Assurance Framework

d) Mortality Improvement – The Way Forward

Dr Hankin presented the Mortality Improvement report which outlined the current position within the Trust as well as the way forward with the community. The presentation highlighted that:

- The Trust had shown a dramatic improvement since January 2019 and that this had been maintained over time.
- There had been an expected increase in mortality rates during Covid-19 which included high risk patients with co-morbidities. The rate for out of hospital deaths, i.e. deaths that had occurred 30 days from discharge, had also increased.
- Concerns regarding patients that were medically optimised for discharge (MOFD) remained and work with system partners to address this was ongoing.
- The improvements in the mortality rates were noted and there was recognition of the need for an integrated response with system partners, to ensure there was early identification of deterioration in the management of chronic disease within the community. The Trust had invited the CCG to attend a Mortality Operational Group meeting (MOG) to discuss these issues.

In response to Mr Birrell's question around how the Trust could affect the management of heart failure in the community, Dr Hankin advised that a discussion around anticipatory care plans would be discussed at a Quality and Safety Committee meeting. He further advised that MOG would be looking at ways in which to extend into the community.

Mrs Armstrong-Child advised that there had been a lot of positive work over the preceding year with the formation of the Hospital Cells within Cheshire and Mersey (C&M) region. Weekly gold command meetings had been taking place between the Trust and both the CCGs in the region and these meetings had been focused around discharges.

RESOLVED:
The Board **received** the Mortality Review update

TB092/21 CQC Progress Report

Ms Lees presented the CQC report following the unannounced inspection and advised that overall, the regulators had noted that the Trust had demonstrated an improvement in leadership and the quality of care. It was also noted that there had been no breaches of regulation or 'must do'' actions following the visit.

Ms Lees advised that the full report as well as the current position alongside the 2019 action plan would be reviewed to determine the status of outstanding actions and a full update would be provided at the next Board meeting.

ACTION: **DoN**

The full report as well as the current position alongside the 2019 action plan would be reviewed to determine the status of the outstanding actions and a full update would be provided at the next Board meeting.

RESOLVED:
The Board **noted** the outcome of the CQC Progress report

TB093/21 Annual Complaints and Service Experience Reports

Ms Lees presented the report which provided an overview on Complaints and Concerns received by the Trust in 2020/2021. Whilst there had been a reduction in complaints overall, there had been a reduction in the number of complaints received during Covid-19. The introduction of the Patient Advice and Liaison Service (PALS) had provided additional support to family and patients. The CQC had acknowledged the work that had been done in this area.

Mrs Gibson requested that equal prominence should be given to compliments as it was important to celebrate successes. Ms Lees advised that this would be taken into account for future reports.

Dr Bricknell commented that the PALs service had reduced the number of complaints by being able to defuse issues that had resulted from miscommunication.

In response to Mr Singh's query around whether the Level 4 and Level 5 complaints were related to a specific Clinical Business Unit (CBU) Ms Lees advised that this would be reviewed, and a thematic review would be presented at QSC for debate and discussion.

RESOLVED:
The Board **received** the Annual Complaints and Service Experience Report for 2020/21

TB094/21 Maternity Report

(Miss Eastham and Mrs Karthikeyan joined the meeting)

Miss Eastham delivered the Maternity Services presentation which focused on

- Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme
- Perinatal Mortality Review Tool (PMRT)

She outlined that one of the outcomes from the Ockenden Inquiry was a list of 12 Urgent Clinical Priorities and the Trust currently demonstrated partial compliance with 4 of these priorities, namely

- Serious Incidents 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. It was noted that each antenatal appointment was viewed as a risk assessment, but that this had not always been communicated to the patient.
- Implementation of a Perinatal Clinical Quality surveillance model. It had been agreed that this would be presented monthly at the Performance Improvement Assurance Development (PIDA) Board and Quality and Safety Committee monthly as an exception report.

A 'Ockenden Portal' had opened on 17 May for a period of four weeks to allow trusts to submit evidence to support progress and compliance against the 12 Urgent Clinical Priorities. All evidence submitted had been ratified by the Maternity Improvement Group and Board.

It was noted that the Trust had demonstrated compliance against all guidelines with the exception of Element 2. Whilst the majority of this Element had been embedded there had been a delay in implementing GROW due to the upgrading of the current Maternity Information system by System C. If the completion of the upgrade was delayed the Trust would need to carry out an audit of 40 patient records to demonstrate that baby growth had been recorded.

The Trust was compliant with six safety actions and were on track to complete another four during June 2021. The Trust was currently not fully compliant with Safety Action 4 as the Neonatal and anaesthetic workforce requirements were not fully compliant. If this was not met an action plan to address the deficiencies would be required and would need to be agreed at board level. It was noted that the finalised CNST report would be presented at the Quality and Safety Committee meeting at the end of June and the Board would be required to sign off the report as compliant before it was submitted by 15 July 2021.

Safety Champions had met bimonthly to discuss any safety issues and had raised a number of concerns which had been actioned. An online bereavement group had been established and this had been well received.

The following key priorities for Maternity services had been set:

- Completion of the 10 CNST safety actions
- Submission of evidence to the 'Ockenden Portal' and the continued progress against the 12 Urgent Clinical Priorities
- Implementation of the continuity of carer model
- To establish a patient experience strategy and staff recognition approach for the CBU

Mrs Armstrong-Child commented that, as a result of the Ockenden report, there was a big push to provide assurance and that this should not be the sole focus of the QSC. The Board would need to be in a position to link assurance provided

to the CQC report and suggested that the Board members visit the Maternity Ward based at Ormskirk.

RESOLVED:
The Board

- **received** the Maternity report
- **noted** the areas of non-compliance as well as the requirement to certify the Trust's declaration following consideration of the evidence provided
- **noted** the PMRT report and the actions taken

TB095/21 Freedom to Speak Up Reports

a) Freedom to Speak Up Q.4 Report

(Rev Abrams joined the meeting)

Rev Abrams presented the report which identified the number of concerns raised through the Freedom to Speak Up Service (FTSU) during the period 1 January until 31 March 2021. It was noted that 14 concerns had been raised through the FTSU service of which 11 were raised directly with the FTSU Guardian and three had been raised with the FTSU Champions.

Mrs Gibson queried what work had been done around alleviating concerns that staff members had around repercussions when they raised concerns. Rev Abrams commented that this was under review and that he would share any lessons learnt. Mrs Armstrong-Child commented that there were lessons to be learnt around managing expectations of the outcome from the start of the process and this included having a discussion around anonymity with each individual. Rev Abrams commented that there was sometimes a perception that nothing had changed and that sometimes the individual needed to recognise that they needed to be a part of the solution.

Mr Singh commented on the cultural changes and processes that had been included in the National Guardians report and requested that this be reflected in our reports going forward and Rev Abrams advised that he would be happy to explore this.

RESOLVED:
The Board **received** the Freedom to Speak Up Q.4 Report

b) Freedom to Speak Up Annual Report

Rev Abrams presented the Annual Report which provided the Board with assurance that staff members were feeling able to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes were in place to do so safely and confidently.

RESOLVED:
The Board **received** the Freedom to Speak Up Annual Report and **noted** the progress made during the 2019-2020

(Rev Abrams left the meeting)

OPERATIONS AND FINANCE

TB096/21 Finance, Performance, and Investment (FPI)

a) Committee AAA Highlight Report

Mr Birrell presented the report detailing discussions held at the FP&I meeting on 24 May 2021. He advised that the Committee were grateful for the work undertaken by Mr Shanahan during his tenure of Director of Finance, and highlighted the following alerts:

- The anticipated income that the Trust would receive from the Health Care Partnership (HCP) in 2021/2222 would be materially lower than planned. Mitigation measures were being identified to help ensure that the Trust can deliver a break-even position this financial year. These implications would be included within the financial plans submitted for Board approval in June 2021.
- There was continued uncertainty around which financial model would be applied if the current system was felt to be unsustainable.

The Committee advised that the Trust was on track to achieve its Referral to Treatment (RTT) Restoration Operational Plan.

The Committee had taken assurance from the Procurement strategy that had been approved subject to the inclusion of an implementation plan that included measurable outputs and milestones.

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. She advised that there was concern around the increase in Accident and Emergency (A&E) attendance and the impact that this would have on the restoration plan and provided reassurance that whilst there had been an increase in demand this was not translating into admissions.

Mrs Morgan highlighted that work around cancer and cancer performance was ongoing and that the pathways had been reviewed. Regular Patient Treatment List (PTL) meetings were being held and governance meetings had been

established. The Trust would be running a 'Get Set for Summer' programme which would incorporate the Perfect Week. This would be directed at reducing bed occupancy and would start on Wednesday 07 June.

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

c) Financial Performance Report

Mr McLuckie presented the Financial Performance report which detailed performance against financial indicators and advised that the plan to break-even for the first half of the financial year would be challenging. He highlighted that unmitigated financial pressures of £3.7 million in H1, and £7.4m in the full year remained and these were based on the current plan assumptions.

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

TB097/21 Finance Reports

a) 2021/22 Financial Plan

Mr McLuckie presented the Finance Report which provided additional information relating to the financial regime for the first half and provided an update on the 2021/22 Financial Plan.

RESOLVED:
The Board **noted and approved** the 2021/22 Financial Plan

b) Month 1 Financial Position Report

Mr McLuckie presented the report which provided the Board with an update on the financial position for April 2021 (month 1).

RESOLVED:
The Board **noted** the Month 1 Financial Position

WORKFORCE

TB098/21 Workforce Committee

a) Committee AAA Highlight Report

Mrs Gibson presented the report and alerted the Board that whilst the sickness absence rate overall had increased to 6% in month against the newly revised target of 5% the HR Business Services team were proactive in their attempts to reduce this figure. Each CBU had created improvement trajectories and a

dedicated HR Advisor had been allocated to provide support to each CBU. A full sickness absence presentation on the approach to reduce this metric would be provided to the Committee in June 2021.

Mrs Gibson advised the following:

- Compliance for PDRs had increased by 4.3% in May 2021. The HR team had been focussing solely on compliance to comply with the organisation's responsibilities and each CBU had created their own improvement trajectories.
- 44 of the 45 International Nurses had passed their Objective Structured Clinical Examinations (OSCEs).
- Significant progress had been made converting from agency to bank and the costs for bank and agency had continued to decrease.
- The Medical Director had attended the meeting to provide an update around the Undergraduate Deans Visit that was scheduled for July 2021. It had been noted that the actions from the 2020 visit were in progress and the Medical Director was confident that the action plan would be produced and completed before the visit. Dr Hankin advised that he discuss this with the Head of Medical Education and provide an update at the next Workforce Committee.

The meeting was assured that whilst there had been a slight decrease in Mandatory Training the target of 85% for compliance had still been attained. Further the Trust had reported a safe staffing in month of 92.5% against the national target of 90%.

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 and commented that Sickness Absence remained a concern and that following the June meeting the actions that had been taken and the impact of these actions would be reviewed. It was noted that the main reason for long term sickness absence was anxiety and depression and that the vast majority of the reasons were external to the Trust. Management plans were in place and this had been agreed with Staff side and mental health.

The Workforce Committee had signed up to be part of a pilot with the Regional Chief People officer and would share the learning from this pilot.

Mr Birrell observed that, whilst there had been a number of interventions to support staff health and wellbeing, there appeared to be no correlation with a reduction in sickness absence. He added that it could be implied that there

could be other factors affecting sickness absence and that this warranted a discussion at Board.

Mrs Royds advised that the Social Forum Partnership had agreed to put all absence management on hold during Covid-19 and that there were a number of staff currently working for the Trust who wouldn't be able to return to work. They were reviewing the list to establish the impact on the numbers.

ACTION **DoHR**
A detailed discussion around sickness absence rates was warranted as the action that had been put in place around staff welfare and wellbeing had not impacted the rate.

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

ITEMS FOR INFORMATION

CONCLUDING BUSINESS

TB100/21 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.

TB101/21 Message from the Board

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

TB102/21 Any Other Business

In concluding the meeting, Mr Masom thanked Dr Hankin and Mr Shanahan for their support and contribution during their time with Trust.

Dr Hankin thanked everyone for support that he had received during his time at the Trust and commented that he would be leaving the Trust and the health care service very satisfied.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:35

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	✓	✓	✓									
John McLuckie			✓									
Graham Pollard	✓	✓	A									
Steve Shanahan	A	✓	✓									
Gurpreet Singh	✓	✓	✓									
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓											
Sharon Katema	✓	✓	✓									
Lesley Neary			✓									
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 01 July 2021

Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
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. **July Update:** Deferred to September meeting.	**Green**
TB092/21	02/06/2021	**CQC Progress Report**	Ms Lees advised that the full report as well as the current position alongside the 2019 action plan would be reviewed to determine the status of outstanding actions and a full update would be provided at the next Board meeting.	**DoN**	02-Jun-21	07-Jul-21	**June Update** : The full report as well as the current position alongside the 2019 action plan would be reviewed to determine the status of the outstanding actions and a full update would be provided at the next Board meeting **July Update:** Included on Agenda	**Included on Agenda**
TB098/21	02/06/2021	**Workforce Committee** **b) Workforce Performance Report**	Mr Birrell observed that, whilst there had been a number of interventions to support staff health and wellbeing, there appeared to be no correlation with a reduction in sickness absence. He added that it could be implied that there could be other factors affecting sickness absence and that this warranted a discussion at Board	**DoHR**	02-Jun-21	01-Sep-21	**June Update:** A detailed discussion around sickness absence rates was warranted as the action that had been put in place around staff welfare and wellbeing had not impacted the rate	**Green**

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	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. **July Update:** The Patient Story was presented at June's meeting. **Action completed**	**Blue**

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB109/21**	**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 June. 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 the staff members nominated by a colleague and recognised in June with a SO Proud badge for living the Trust's values.

- Jill Downes, Clerical Officer.
- Kirsty Slinger, Hospital Alcohol Liaison Team.
- Mel Pinnington, RGN & Clinical Educator – Critical Care Unit.

1.2 Thanks a Bunch

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

- Our volunteer workforce as part of National Volunteers Week
- Sapphire post-natal maternity team.

1.2 Safeguarding Ambassadors

We recognised our first group of Safeguarding Ambassador in June. They have received additional training to enable them to support staff, identify and report safeguarding concerns, and in assessing capacity and applying the principles of the Mental Capacity Act in everyday practice:

- Gayle Carson, Christine Brindle, Kirstie Blackham, Linda Chappell, Sophie Williams, Kerry Mason, Amy Brindle, Marina Mawdsely, Maria Hancock, Michelle Ngo, Janine Mosher, Victoria Wood, Sue Raju, Matthew Gregory, Caroline Brahimi.

1.3 Care Certificates

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

- Susan Harris, Den Den, Jane Salter, Shirley Dickinson, Kyle Moore, Clare Nugent, Lesley Mcabe, Mandy Turner, Holly Porter, Liz Fyles, April Jones.

1.4 Young Doctors take Declaration of Geneva

Congratulations to our trainee doctors who are now ready to practice after taking the Declaration of Geneva. The pledge, which is the successor to the Hippocratic Oath, is normally taken at graduation. However, Covid-19 restrictions mean these are unlikely to be until the autumn – long after the trainees need to start practising in August. Instead, the ceremony and a celebration took place in the Clinical Education Centre at Southport Hospital attended by Professor Hazel Scott, Dean of the School of Medicine at University of Liverpool.

1.5 Consultant Paper published in British Medical Journal (BMJ)

Paediatric consultant Dr Kunle Oyeduken has had a paper published in the BMJ. Kunle has specialist interests in dermatology and epilepsy. His paper was: Meningioangiomatosis: an uncommon cause of focal epilepsy with characteristic neuroimaging and neuropathology.

2. News and Developments

2.1 Standard met again for Accreditation as Major Trauma Unit

Southport and Formby District General Hospital has again achieved the required standard for accreditation as a Major Trauma Unit for 2021-2022.

Cheshire and Merseyside Major Trauma Network, which conducted the review, said clinical standards had been met in the most challenging of times and it was "a credit to those delivering and supporting the service". The network team said the review demonstrated excellent clinical engagement and a continued desire to improve services offered to patients suffering from major trauma.

The following areas of good practice and/or significant achievement were noted:

- Network pathway for spinal fractures has been successfully adopted to good effect.
- HIT score also adopted and is making a difference.
- ED nurses have been enrolled on Liverpool John Moore University emergency care course; some have completed it and feedback had been excellent.
- Continuation of simulations throughout Covid-19.
- Continued success of the TWIST pathway.
- Ratification and introduction of management of vertebral fractures guidelines.

2.2 Southport Ward Changes Support Extra Capacity at Ormskirk hospital

To improve surgical pathways for both patients and staff, a new ward configuration has been introduced at Southport Hospital which supports additional capacity at Ormskirk Hospital.

The effective management of patients during Covid-19 also revealed the need to introduce new routes for complex surgical pathways. This includes the introduction of a post-operative care unit based in Critical Care.

Increasing the capacity at Ormskirk for not only orthopaedic, but general surgical specialities will provide improved patient flow and experience. The change will also provide access for surgical rehabilitation beds within the expanded G Ward with appropriately trained staff to manage these patients.

2.3 Urgent Care Demand

The Trust has been extremely busy over recent weeks dealing with unprecedented levels of demand for urgent care services, an increase in Covid-19 patients being admitted to our hospital and the ramping up of our elective restoration plan, all whilst supporting staff health and well-being.

Attendances at our A&E departments in May 2021 hit record levels with 25 May 2021 seeing our highest ever number of attendances. The challenges we have faced in Southport and Ormskirk NHS Trust are similar to those experienced across the Cheshire and Merseyside region. As a result of the increase in attendances, our patients waited longer than we would have liked, however, despite the increased demand, the Trust continued to deliver good ambulance handover times and zero patients being cared for on our corridors.

From an elective restoration plan perspective, as at May 2021, the overall Trust position is positive and at a Trust level we are on track for delivering against our elective plans for inpatient, day case and outpatients in line with 2019/20 levels, although there are some challenges at an individual

specialty level which the teams are working through. The Trust are also on track for treating those patients who are deemed to be the most clinically urgent.

As a consequence of the rise in community rates of Covid-19, we have seen an increase in Covid-19 positive patients being admitted to our hospital. As at the time of reporting we are seeing an increase in Covid-19 positive patients in our bed base. Over the last 7 days, Cheshire and Merseyside have seen a 43% increase in Covid-19 positive hospital admissions.

2.4 Shaping Care Together (SCT) Programme Update

Shaping Care Together is progressing well and on track to delivering the pre consultation business case and associated evidence in early December for the NHS England Stage 2 assurance process. Following a review of the engagement process in April, a revised website and improved questionnaire has been launched which has already seen 1,700 visits and received over 370 questionnaire responses (121 of which were Trust staff) since the launch date of the 17 May. Dedicated resource has been secured with the two Council of Voluntary Services (CVS) in West Lancashire and Sefton who are helping our engagement have the reach in to our wider communities. There have been three rounds of clinical and care workshops to develop the models of care for urgent & emergency care, frail & elderly care, care for children, maternity and neonatal care, gynaecology, sexual health and planned care. Alongside this work, the Clinical and Care Congress have drafted a hurdle criteria to enable the emerging long list of solutions to be easily translated to a shorter list upon which we can do a robust evaluation and appraisal can be conducted with our patient group for the final short list.

3. Trust News

3.1 Patient Experience Conference

Thank you to each of the teams who took part in our first patient experience conference at the Southport Conference Venue on Friday 25 July. Numbers attending were limited to 45 by Covid-19 restrictions but those who joined us heard from colleagues across the Trust about their work improving the experience care for patients.

3.2 Deaths of Jenny Hughes and Paul Lawrenson

Our condolences go to the families of two members of staff who died in the past month.

Jenny Hughes had worked for the Trust for 17 years and was one of our first female porters.
Electrician Paul Lawrenson had been a member of the Estates maintenance team since 2015.

Their funeral corteges passed Ormskirk and Southport Hospitals, respectively, for colleagues could pay their respects.

4. Reportable Issues Log

Issues occurring between last date and most recent reportable data (21.05.21 – 24.06.21)

4.1 Serious Incidents and Never events

In the reporting period:

- No never events have been reported.

- Three incidents have been reported to StEIS. One is in relation to a fall and two reported within maternity. All are in the process of investigation.

4.2 Level Four and Five Complaints

There were 4 level four complaints in the time period. Two relating to treatment and care and two safeguarding concerns.

4.3 Regulation 28 Reports

There were no regulation 28 reports in the period

5. Media Coverage

- Hospital porter takes up new role as borough's mayor (Champion News, May)
- Southport and Ormskirk hospitals to celebrate work of volunteers (In Your Area, 29 May)
- NHS trusts awarded freedom of borough (Southport Champion, 2 June)
- Nurse 'forced to resign' over sick pay and bullying' (Southport Visiter, 10 June)
- Sefton hospital records first coronavirus deaths in nearly two months (Liverpool Echo, 16 June)

6. Risk Register and Board Assurance Framework

No significant changes to report.

Trish Armstrong-Child
Chief Executive
23 June 2021

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	AUDIT COMMITTEE
MEETING DATE:	09 June 2021
LEAD:	Mr Jim Birrell

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- It was suggested that the Standing Financial Instructions include a new section outlining a requirement to undertake post-completion evaluations of both capital and revenue business cases.

ADVISE

- Based upon positive comments from both External and Internal Auditors, together with a discussion on key aspects of the figures, the Committee will recommend to the Board that it adopts the audited 2020/21 financial statements.
- The External Auditor's assessment of the Trust's Value for Money status would be included in the External Auditor's Annual Report that will be issued in August. It is anticipated that the section will be more detailed than in previous years because the reporting arrangements have been enhanced.
- Updated information on litigation claims suggests that over the last ten years the Trust had contributed approximately £41m to NHSLA whilst settlements had been in the region of £14.7m.
- The Audit Committee asked that a more pro-active approach be taken to compliance with Standing Order 1.6 that requires the Trust to issue updated copies of Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation to members and senior officers. This was likely to include electronic evidence that the relevant people have both seen and read the documents.
- The Internal Audit Plan for 2021/22 was approved and the Committee asked that a review of clinical outcomes be pencilled into the 2022/23 programme.
- Disappointment was expressed at the Quality Accounts, which were felt to be incomplete, disjointed and generally missing an opportunity to present the Trust in a good light. It was recognised that further work was being undertaken but the Committee highlighted the need for editorial oversight and ownership in the relatively short period before they are signed-off.
- The Audit Committee's Terms of Reference were agreed subject to some minor amendments to be agreed by the Committee Chair and the Associate Director of Corporate Governance
- A review will be undertaken of the delegated limits for Losses & Special Payments - at present all items over £49,999 require Board approval

ASSURE

• The Committee expressed their support for the Trust's Freedom to Speak Up, (FTSU), arrangements and the updated FTSU Policy. It was proposed that consideration be given to assessing whether staff that have used the FTSU system have subsequently felt disadvantaged or discriminated against through raising concerns. • With regards to the financial statements, both External and Internal Auditors offered substantial assurance on the controls, systems and accounting policies underpinning the documents.	
New Risk identified at the meeting	No new risks were identified at the meeting.
Review of the Risk Register	

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB111/21**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK (BAF)**		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Simon Regan, Deputy Director of Quality, Risk and Assurance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls.

This BAF reflects the existing Trust Strategy and whilst it was not subject to extensive review, throughout the last financial year, it progressively developed through consultations with the Executive Directors and reviews by Committee Chairs led by the Audit Committee. This has ensured that there was a clear updated position and that all actions were progressing in line with agreed timelines. These actions have continued to be monitored monthly at ETM. Since the last update on the Board Assurance Framework (BAF), there have been no changes to the risk score.

Recommendations

The Board is asked to **receive** the Board Assurance Framework.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Simon Regan, Deputy Director of Deputy Director of Quality, Risk and Assurance	Sharon Katema, Associate Director of Corporate Governance

Southport and Ormskirk Hospital NHS Trust

BOARD ASSURANCE OVERVIEW (UPDATED 30 JUNE 2021)

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

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

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

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

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

Inherent Risk			Risk as at 30/06/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	2	4	8

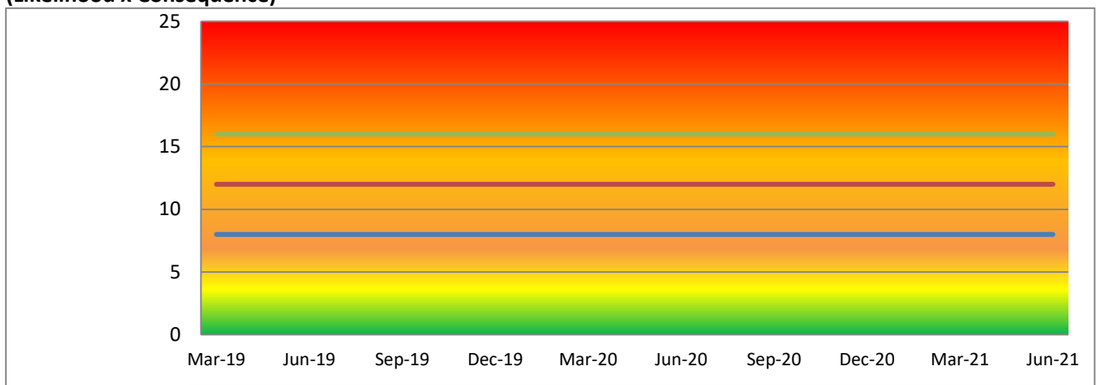
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing four priority areas: • Care of the deteriorating patient; • Care of Older People; • Infection Prevention and Control; • Medicines Management. 4. Risk Management Strategy. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. 12. Training programme (mandatory and non-mandatory). 13. CQC action plan to address areas of underperformance highlighted on inspection. 14. Supervision and education of clinical staff across all professions. 15. Application of Patient Safety and other safety alerts. 16. Patient Safety Specialists appointed. 17. Cycles of business for governance meetings 18. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development.	**LEVEL 1** (Operational Management) 1. Health and Safety Committee 2. Risk and Compliance Group 3. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 4. CBU Governance Meetings 5. Harm free care panel 6. Serious Incident Review Group 7. Alert, Advise, Assure (AAA) reports 8. Patient feedback (FFT/Patient Surveys) 9. Clinical audit reports 10. Mortality and SJR Process. 11. Review of documentation and quality indicators through use of perfect ward. 12. Health and Safety Inspection Programme 13. Freedom to speak up guardian 14. IPC Board Assurance Framework (BAF) **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SONASS ward accreditation programme 8. VitalPac deterioration measures	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests and audit. 3. Medical examiners and medical examiner's office not fully established.	1. KPI dashboards for wards and CBUs to be reviewed, including visibility at key governance/committee meetings. - **COMPLETE** 2. Cycle of business to be reviewed for Trust-wide and CBU governance meetings. - **COMPLETED reviews and to be implemented** 3. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **–** ~~By end March 2021~~ **June-21 Update:** Quality Improvement Plan to be presented to Quality and Safety Committee in June and Board in July-21. 4. Clinical workforce strategy to be completed **– by end of Dec-21.** 5. Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed. – ~~By end March 2021~~ **June-21 Update:** This will be part of the Clinical Workforce Strategy referenced in action 4 and agreed it won't standalone. 6. Risk management training with senior leaders in the organisation **– COMPLETE – ongoing training in place** 7. Complete CQC Must and Should Do actions – ~~By end of Jan 2021.~~ **June-21 Update:** The process of validation and monitoring completion of the actions has been strengthened. Whilst progress has been made, all actions aren't fully complete, some of which have been affected by COVID/other factors. QA Panel being set up to finalise current Trust position before agreeing trajectories for completion. 8. Review KPIs that goes to all governance meetings - **COMPLETE** April-21. All KPIs in IPRs reviewed. 9. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. ~~By end of Jan 2021.~~ **Revised to Sep-21:** The sharing of lessons learnt has been enhanced significantly but further work is planned with Clinical Audit and

			LEVEL 3 (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits, Insight Report, Outlier Alerts and engagement meetings 4. Healthwatch 5. National Audits 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Guardian of Safe Working Reports. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account		CBUs to test that completed actions/changes are embedded. ~~10. Complete the full roll-out/reporting of Perfect Ward app measures – **COMPLETE**~~ ~~11. Review health and safety/fire risk assessment/audit programme – **COMPLETE**~~ 12. Complete appointments to medical examiners roles and fully establish programme to review all deaths – ~~by end of Feb 2021.~~**Revised to Jul-21:** There have been delays in implementing due to COVID-19 and delays in recruitment. 13. Nurse establishment review to be completed – **COMPLETE and ongoing** ~~14. PIDA, agreed suite of measures in place. - **COMPLETE**~~ ~~15. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. - **COMPLETE**~~
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge				

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

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

RISK TRACKING	Linked Risks: 6	Comments
Risk Rating: Initial 4 x 4 = 16 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	a) 1862 – Safe Staffing b) 1622 – Shortage of middle grades in obs & gynae c) 2122 – Medicines Management d) 2056 – Missing Patient appointments e) 2226 – Inadequate staffing within Anaesthetics f) 2074 – Consultant Medical Vacancies g) 2218 – CQC compliance	**Update – July 2021** • The strategic risk and associated linked risks have been reviewed and this remains a high risk. • Since the BAF was last updated, one action has been completed, one aligned with another action and one action has seen the target date revised. • The controls and actions have been reviewed in line with Interim Report on Controls and Assurances which was presented at Audit Committee in January 21. • A full review of SO1 will be undertaken by the new Medical Director in Q2 having only started at the Trust in June 21 • It's anticipated the completion of the remaining BAF actions will further enhance the controls and assurances with the aim of reducing the risk to achievement of the strategic objectives.



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

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

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

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

Inherent Risk			Risk as at 30/06/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

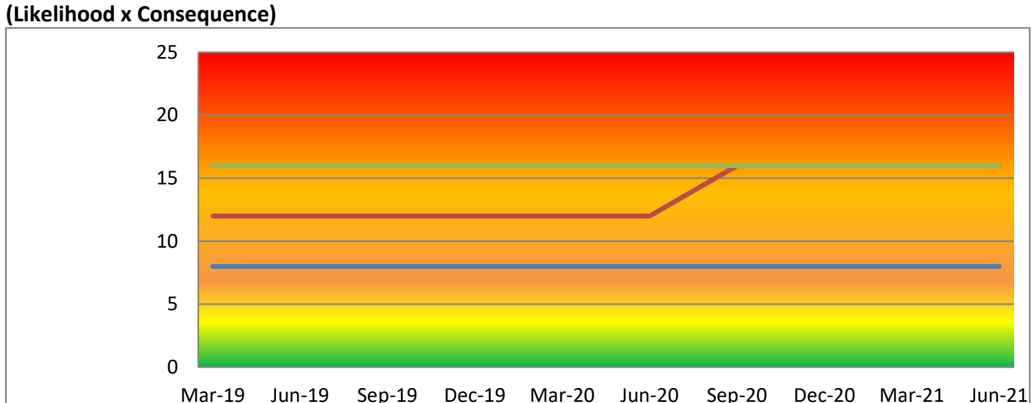
Risk Description: If the Trust cannot achieve its key performance targets it may lead of loss of services

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it may lead of loss of services **CAUSE** Lack of clear vision for transformation and partnership working in fragile services; inability to recruit in certain medical specialities; year on year rise in demand for urgent and emergency care; capacity and demand; flow through the hospital; system discharge challenges; COVID-19 impact – causing delays in discharge, elective, diagnostic and cancer pathways. **CONSEQUENCE** Delays in the provision of care and treatment resulting in poor patient outcomes and standards of care; over-reliance on temporary workforce leading to increasing prevalence of fragile services; failure of national performance target (cancer, referral to treatment (RTT); failure to reduce delayed transfers of care; failure to deliver NHS constitutional targets; duplication of services with negative impact on CIP; impact on patient experience; intervention by regulator(s)/ commissioner(s);	1. Shaping care together programme. 2. Southport and Ormskirk Admissions and Discharge Working Group. 3. North Mersey A&E Delivery Board. 4. Single accountability framework for reviewing CBU areas for development/strengths. 5. Part of C&M hospital cell group monitoring COVID-19 recovery and sharing capacity where possible. 6. Bronze, silver, gold command structure for oversight and decision making. 7. Weekly Senior Operational Leadership Team (SOLT) meetings 8. Agreed in-hospital winter plan 2020/21. 9. Directorate Manager role that is solely responsible for Access - providing greater strengthen in governance and compliance. 10. Quality impact assessments (QIAs) for all service changes that are considered. 11. Trust policies and procedures updated in line with SITREP requirements / guidance against the constitutional standards. 12. Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. 13. Clinical prioritisation. 14. Access policy for validation of all patients on waiting lists. 15. Use of additional locations to provide treatment where possible. 16. Risk Management Training 17. Agreed out of hospital (system) winter plan 2020/21. 18. System wide capacity and flow meeting held twice weekly to review system discharge delivery. 19. Comprehensive Service Review Programme developed and in progress includes but not limited to fragile services	1. The workforce of the Trust does not have the sufficient level of expertise to ensure QI methodology can be applied. 2. Non-standardised Trust approach to quality improvement. 3. Clinical workforce strategy not fully developed. 4. Partnership working not fully established in all fragile services. 5. Insufficient economies of scale to deal with social distancing / workforce impacts arising from COVID-19.	**LEVEL 1** (Operational Management) 1. Operational Performance & Improvement Group (OPIG) oversees work against the four operational priorities: ○ Theatre Utilisation; ○ Patient Flow improvements; ○ Operational productivity; ○ Cancer wait improvements. 2. Risk and Compliance Group. 3. Clinical Effectiveness Group 4. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 5. CBU Governance Meetings. 6. Local IPRs in place to monitor performance. 7. Weekly RTT restoration Group meeting in place from March 23rd to review performance against S&O plan 8. Urgent and Emergency Care Programme Board **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. Quarterly report to FP&I on progress against each key constitutional standard to offer assurance in actions being taken to maintain and / or improve performance 3. S&O Urgent Care Board 4. OPIG key metrics agreed dashboard in review by BI to ensure integrated PMO approach 5. Separate monthly report to FP&I on elective restoration 6. Separate monthly report to FP&I on Urgent and Emergency Care	1. Not always delivering the 95% standard of all patients presenting to ED being seen, treated and discharged / transferred within 4 hours. 2. During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard. 3. Not consistently delivering the national standard due to workforce challenges across a number of tumour groups in particular Haematology and Head & Neck services.	1. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– ~~By end March 2021~~ June-21 Update: Quality Improvement Plan to be presented to Quality and Safety Committee in June and Board in July-21. Should be monitored through SO1** 2. Clinical workforce strategy to be completed **–** ~~by end of March 2021.~~ Revised deadline to end of Dec-21. 3. Engage system partners and agree sustainability plans for fragile services **– ~~by end of March 2021~~. June 21 Update - Conclude high level assessment of all services by end June 2021, establish fragile services group – July 21, Identify any further 'red' risk areas by end of July 21** ~~4.~~ Develop sustainable plan to address validation issues in relation to the non-RTT tracker. **– ~~Action on track for completion:~~** ~~Plan and Business Case approved at Board and approach endorsed by NHSE/I. AfC approval not completed substantive recruitment outstanding~~. **June 21 Update:** Completed 5 x WTE in post and the work on Non RTT tracking has begun. Trajectory set for 3 months. Ongoing review 5. Use of Resources Group is now established first meeting to be held 29 March with DoF Chair Update: Revised purpose, ToR and membership under review by DoF – expected end Jul 21. 6. Business planning process in place, 'lite' in Q4 2020/21 full review due in Q1 2021/22 following national guidance **Jun 21 Update** – plans set

	reputational damage; loss of public confidence.	20. Operational Improvement Group re-established to support standard, consistent and measurable PMO approach to service improvement 21. Fragile service programme in place; includes development of options and ongoing monitoring of progress 22. Use of Resources Programme established to support well led approach for clinical and corporate services.. 23. Established gold command of the day to ensure flow and clear escalation 24. Frequency of gold/silver meetings revised based upon trigger alerts linked to COVID-19 admissions. 25. RTT restoration plan being monitored on a weekly basis and reported to gold/ETM weekly. 26. Non RTT trackers now in place with planned programme of work		**LEVEL 3** (Independent/Semi-Independent) 1. NHSI Single Oversight framework and monitoring arrangements 2. CQC 3. CCG monthly quality and performance meetings. 4. NHS benchmarking data including Model Hospital Dashboard 5. Getting it right first time (GIRFT) programme. 6. Cancer alliance oversee delivery and performance regarding cancer metrics. 7. Internal and External Audit reports 8. Peer review boards 9. Urgent and Emergency System Board 10. Dr Foster reporting 11. Integrated QIPP reporting with CCGs 12. Weekly NHSE Elective Restoration meetings in place 13. Weekly NHSE urgent and emergency care meetings in place		for H1 21/22 and awaiting further national planning guidance for H2. Expected summer 21 7. PMO alignment to CBUs to support standardisation of approach, independent reporting and QI approach. **Jun 21 Update**: Completed
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 2 x 4 =8 **(Likelihood x Consequence)**  	a) 1987-Haematology/ Oncology service b) 1688-Anaesthetic staffing c) 2056 – Missing Patient appointments/admissions	**Update – July 2021** • The strategic risk and associated linked risks have been reviewed remain extreme. • Since the BAF was last updated, ○ two actions have been completed on time. ○ Four actions have seen the target date revised, which is interdependent with other strategic risks and has been amended to fit in with programmes of work (fragile services, quality improvement plan, business planning and UoR) • At the last formal update, the risks remain are predominantly associated with: ○ Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment. (COVID secure pathways) ○ Fragile services. ○ The unresolved issue of non-RTT tracker and potential associated impact on patients. • Detailed restorations plans and trajectory have been developed and submitted and these are monitored on a weekly basis and gold and ETM. • Reporting weekly into Gold Command and SOLT and Monthly into PIDA.

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

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

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

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

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

Inherent Risk			Risk as at 30/06/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	3	4	12

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question. **CAUSE** Fluctuating income and activity; Inability to deliver the required levels of CIP; inability to control agency costs and premium payments to support fragile services; insufficient liquid cash to meet expenditure obligations on a monthly basis; capital cost estimations are higher than originally predicted. **CONSEQUENCE** Shortfall in funding (PSF/FRF); reductions in services or the level of service provision in some areas; potential loss in market share; regulatory intervention; lack of financial stability; missed opportunities to invest in services and new technologies; failure to deliver the capital programme.	1. Financial Systems and processes. 2. Scheme of Reservation and delegation 3. Standing financial instructions 4. Budget holder training. 5. Short term financial plan for the Trust. 6. Cheshire and Mersey Health Care Partnership (HCP) 5 year plan 7. Business Development and Investment Group (BDIG) approves all business cases and reports to FP&I Committee. 8. Capital Investment Group 9. Strategy Task and Finish Group 10. Shaping care together programme 11. Health Trust Europe (HTE) Procurement Framework 12. Cheshire and Mersey Framework 13. National Agency Team Support 14. People Activity Group (PAG) 15. 2020/21 Cost improvement (CIP) programme commenced and indicative plan for 2021/22. CIP targets have been shared with CBUs and Corporate functions 16. Smart sheet software from PMO. 17. e-Rostering 18. Financial Management Framework 19. Use of Resources Action Plan in place. 20. Implementation of strategy for the roll out of patient level costing to inform clinical understanding of cost drivers –	1. Due to COVID-19 unable to accurately forecast the Trust's income. The temporary arrangements for 2020/21 will eventually come to an end but there is no clarity on the future of the Payment by Results (PbR) tariff. 2. Currently no financial recovery plan that delivers break-even/ services the underlying deficit. 3. Lack of three year medium term financial model, taking into account current position and savings from any reconfiguration in line with Sefton Transformation Board Strategy. 4. E-rostering system not fully utilised across the Trust.	**LEVEL 1** (Operational Management) 1. Finance, Performance and Investment Committee 2. Audit Committee 3. Hospital Management Board 4. Business Development and Investment Group (BDIG) 5. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 6. Model Hospital Group 7. Trust Board 8. Detailed agency spend reviewed by Efficiency Programme Group (EPG) 9. Monthly CIP review meetings 10. Monthly cash flow forecast **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report (IPR) 2. Monthly financial position reports/CIP Reports to HMB, FP&I Committee and Board 3. Activity and performance reports **LEVEL 3** (Independent/Semi-Independent) 1. NHS England/Improvement 2. CQC 3. CCG 4. Internal Audit 5. External Audit 6. National Agency Team reports	1. Inability to monitor trajectory against financial recovery plan until developed. 2. Robust tracking of CIP programme. 3. High level forecasting is a manual driven process.	1. Develop scenario-based approach to business plan/budget setting for 2021/22 taking account of the COVID-19 trajectory and emerging financial arrangements for 2021/22 – ~~by end of March 2021~~. **June 21 Update**: Delayed due to COVID, further discussions taken place with SBS, IT issues need resolving – by end March 2022. 2. Develop financial framework to underpin Shaping Care Together programme, setting out affordability and potential financial improvement/recovery ~~– by end of March 2021.~~ **June 2021 Update**: Revised target date to September 2021. 3. Develop reporting mechanism to track progress with financial improvement recovery plan – ~~by end of March 2021.~~ **June 2021 Update:** Revised to September 2021. 4. Internal audit review of CIP programme **–** ~~by end of March 2021.~~ **Revised to Q2 2021/22:** to fit in with the embedding of the new actions included. 5. Establish process for identifying, implementing and monitoring delivery of efficiency/productivity (CIP) **–** ~~by end of February 2021.~~ **June 2021 Update:** New additions to Executive Team currently reviewing process – by end July 2021. 6. ~~Implement and~~ report progress against the Use of Resources action plan **– report to FP&I Committee by end of March 2021. June 2021 Update**: Reviewing Use of Resources workplan – **by end of July 2021**. 7. E-rostering to be fully rolled out in all areas – ~~by end of March 2021~~. **June 2021 Update:** Revised target date to September 2021. 8. NHS Shared Business Services developing a new forecasting and budgeting tool – ~~to be tested by end March 2021 with aim to use in 21-22 financial year.~~ 9. See 1 above

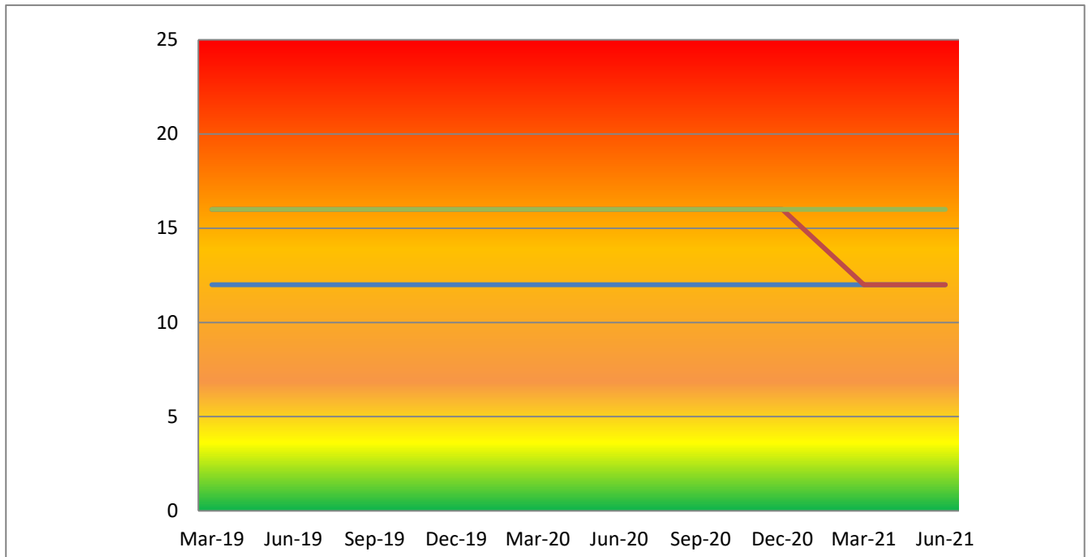
The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide care efficiently and productively, within agreed financial limits

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

RISK TRACKING

Risk Rating: Initial 4 x4 = 16 Current 3 x 4 = 12 Target 3 x 4 =12
(Likelihood x Consequence)



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

Linked Risks: 2

1942: Eradicating Trust deficit by 2023/24

1688: Anaesthetic staffing

Comments

Update – July 2021

- The strategic risk and associated linked risks have been reviewed and this remains a high risk.
- Since the BAF was last updated, one action has been completed, one aligned with another action and three actions have seen the target date revised.
- The controls and actions have been reviewed in line with Interim Report on Controls and Assurances which was presented at Audit Committee in January 21.
- A full review of SO1 will be undertaken by the new Director of Finance in Q2 having only started at the Trust in June 21

It's anticipated the completion of the remaining BAF actions will further enhance the controls and assurances with the aim of reducing the risk to achievement of the strategic objectives.

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	**4**	**Risk Description**	**If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience**

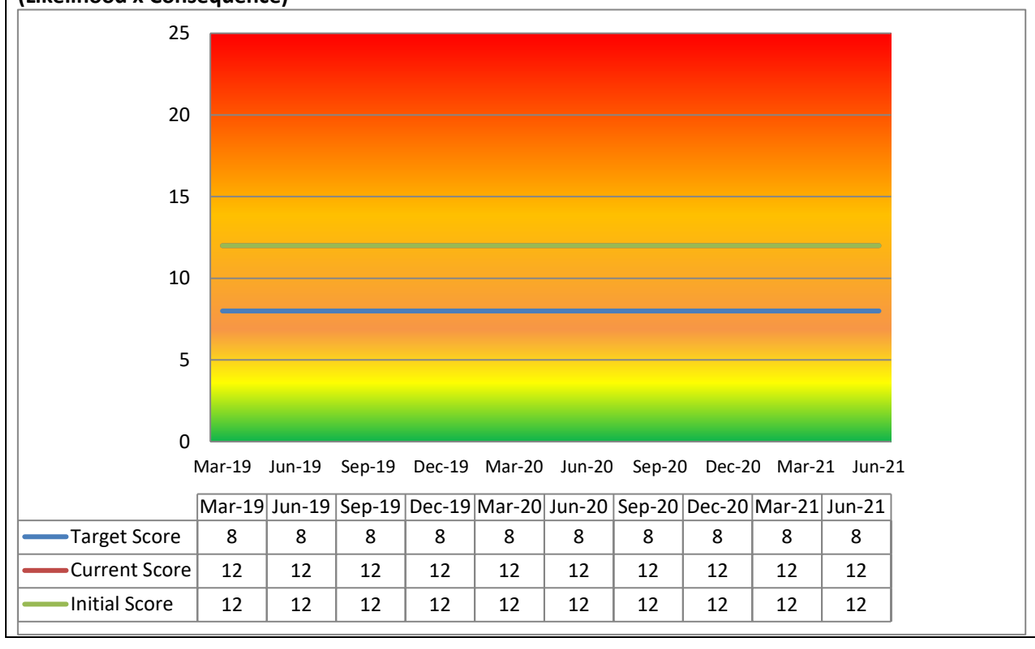
Inherent Risk			**Risk as at 30/06/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Our Resourcing Plan (Strategy supported by clinical workforce plan). 3. Inclusive recruitment and selection processes in place 4. Overseas Recruitment Campaign for Nurses 5. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 6. Job plans for medical staff. 7. Corporate staff induction 8. Quality PDR process and career development discussion 9. Flexible working options in place including team rostering 10. Ward/departments non-medical staffing position is controlled through: ○ 3 x daily at staffing huddle; ○ 7 day staffing matron in place for oversight and management; ○ Weekly staffing review and sign off; ○ Roster sign off meeting. 11. People Activity Group (PAG) with oversight of business cases for additional staffing 12. Leadership development programme available to staff	1. Updated Resourcing Plan required and no clinical workforce plan in place 2. Low number of applicants from BAME backgrounds successful at interview 3. In need of earlier identification of junior doctor rota gaps and proactive block booking to address. 4. Alignment of job planning rounds to business planning cycle 5. No physical induction or viable alternative in place during pandemic 6. Poor PDR compliance rate 7. E-rostering system not fully utilised across the Trust and limited options for flexible working 8. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management	**LEVEL 1** (Operational Management) 1. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 2. Clinical Effectiveness Group 3. Risk and Compliance Group. 4. Clinical Effectiveness committee; 5. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 6. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion; 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Staff Survey & Quarterly Staff FFT/Survey 9. GMC Medical Staff survey – annual 10. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports	1. Sickness absence above target 2. Low compliance rates for PDR completion 3. High nursing vacancy rates 4. A number of medical vacancies have been vacant for a long time	1. Our Resourcing Plan formally documents all short to medium term recruitment activity to reduce immediate gaps and support Fragile Services. Due to be approved at Workforce Committee **in July 2021**. 2. Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed. Aiming for this to be in place by the **end of December 2021**. 3. Engagement planned with staff networks to review R&S process to identify improvements, enhancements and positive action approaches. **Date to be arranged before September 2021.** Involve the International Nurse cohort to act as a pilot for developing support to aid career development at the Trust. **Terms of reference to be agreed by August 2021.** 4. Early liaison with Lead Employer and progression to fill gaps by Trust at easiest opportunity – **review mid-June 2021 with update report on August 2021 rotation to Workforce Committee in June 2021.** 5. Alignment of business planning to Job Planning Round 2021. **2021 Round still in progress.** 6. Review of Trust on boarding and induction process in progress – to be completed **by July 2021** with the launch of an online induction programme. 7. PDR Improvement Plan in place and each CBU are monitoring progress against an improvement trajectory. Focus on accessibility of key documents and guidance to support PDR discussion, and improve recording and reporting of PDRs completed **by September 2021** 8. E-rostering system now being rolled out to remaining departments (**target completion date September 2021**); departments identified as pilots for team/self-rostering is now underway – **evaluation timescale yet to be agreed**; agile working group developing principles for hybrid

	commissioner and patient confidence in provision of services.	13. Effective approach to supporting attendance to reduce sickness absence levels.		9. Guardian of Safe Working Hours Report.		working and review of flexible working policy to be piloted with CMO staff in **July 2021.** 9. Review of supporting attendance policy to commence and support being access from NHS England/Improvement to address areas identified as outliers compared to Trust's with lower absences. Further meeting to take place with NHSE/I **w/c 12th July 2021**. 10. Each CBU has developed an improvement trajectory showing planned reduction in sickness absence over next 3 months and progress to be monitored through monthly PIDA **from April 2021.** 11. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust – **aim to appoint by September 2021**
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Merseyside and Lancashire

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

RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)** 	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce	**Update – July 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • A full review of the controls and assurances has been undertaken, recognising the shift in focus following the implementation of the Trust's Our People Plan. The actions have also been reviewed to address the gaps identified. • Since the last review, the Clinical Education Review findings have been finalised and report submitted to Executive Management Team to inform next steps. • It is anticipated the completion of the actions for 2020/21 will further reduce the risk to achievement of the strategic objectives.

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

Risk Description: If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

Assurance Committee: Workforce Committee
Executive Lead: Director of HR and OD

RISK ID	5	Risk Description	If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Inherent Risk			Risk as at 22/06/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	**12**	3	4	**12**	2	4	**8**

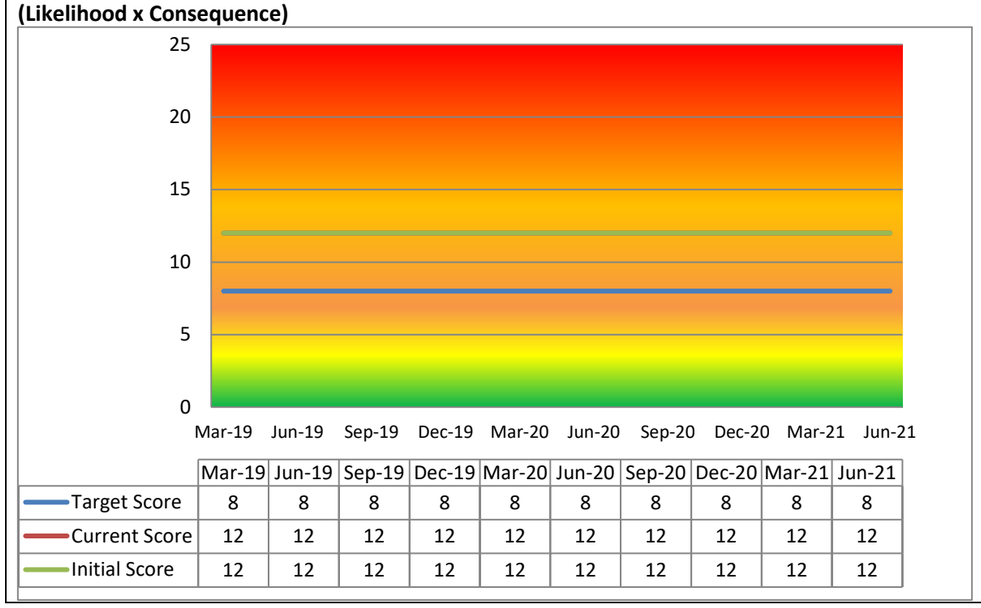
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours; leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Trust Values & Behaviours Framework 3. Trust values and behaviours embedded in the employee life cycle 4. Value of Our People Inclusion group supporting delivery of NHS Promise/Our People Plan 5. Our Equality, Diversity and Inclusion Plan in place to deliver Trust's mission and objectives 6. Equality, diversity and inclusion networks in place 7. Just and learning principles embedded at the Trust, particularly in processes for raising/investigating concerns and lessons learned 8. Freedom to speak up guardian 9. Joint negotiating committee (JNC) 10. Staff Stories presented to Workforce Committee 11. Team development support available to promote positive relationships 12. Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available 13. Mandatory and role specific training programme in place 14. Quality PDR discussions to promote positive behaviours 15. Talent management framework 16. Apprenticeship programmes leadership & management offer Levels 3-7 17. Board role modelling and visibility through: ○ Back to the floor sessions;	1. Awareness of Trust Values and Behaviour framework 2. Limited alignment of values to key stages in employee life cycle 3. Up to date EDI mission and objectives required 4. Low participation in staff networks 5. Limited awareness of Just and Learning Culture and alignment to processes for looking into incidents/lessons learned 6. Team development interventions are currently expensive and resource intensive 7. No talent management/succession planning frameworks in place 8. Low visibility of leadership team reported in recent Staff Survey 9. Pause of Board Development sessions due to COVID-19.	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training; ○ PDR completion; ○ Sickness rates. 2. Turnover; 3. Vacancies; 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC	1. Staff Survey Engagement score has improved in year and but remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address relatively poor engagement with equality, diversity and inclusion networks. 4. High number of employee relations cases and concerns raised through Freedom to Speak Up linked to negative interactions and relationship issues	1. Work stream established as part of Valuing Our People Inclusion Group focussed on embedding the Trust's Values and Behaviours. Staff communication and engagement plan being developed with the Comms & Marketing team **(Completed)** 2. Initial focus on embedding Values and Behaviours in Induction and PDR processes. **To be implemented by Sept21.** 3. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. Starting with an externally facilitated session with Board **on 7 July 2021**, to help shape Trust's EDI Mission and Objectives. 4. External support accessed to improve engagement with staff networks. Opportunities identified to learn from staff lived experiences to shape practice going forward – EDI Action Plan, R&S process and staff stories at Valuing Our People Inclusion Group. Update to be provided to VOPIG in **Sep 2021.** 5. Just and Learning Culture group set up with initial focus on a Trust-wide civility and respect campaign (linked to Values and Behaviours) and review of past cases to identify learning. Progress reviews at VOPIG in **September 2021.** 6. 6 Schwartz Round facilitator regional training places secured and HR Business Partners to be upskilled to support team development intervention by **Sep 2021**. 7. Awaiting launch of national talent management/succession planning framework to apply at the Trust. 8. Back to Floor sessions reinstated for Board members; 11 Wellbeing Guardians assigned to hotspot ward areas; Ward Buddy initiative to be launched **in July 2021** assigning Wards to Directors and Deputies; increased presence of Executive Team at Ormskirk (permanent office base identified) 9. At our Best leadership programme to ~~**re-commenced in Spring 2021** (on track~~ – will commence in Autumn in line with COVID-19 restrictions).

		○ 15 steps walkabouts in wards/departments 18. Board Development sessions planned throughout the year		3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		10. Medical Leadership Programme for 28 x Consultants & SAS Doctors commenced 1st March 2021 for 6 months **due in July 2021**. 11. PDR Improvement Plan in place which includes improved training and guidance for appraisers and appraises to hold effective discussions **by September 2021** 12. Work programmes identified by the Valuing Our People Inclusion group from feedback from staff survey to improve staff engagement score. Quarterly Staff Survey to be **launched on 1st July** and support regularly monitoring of impact of the VOPIG programme of work. 13. Increased engagement with the regional mediation service to assist in the informal resolution of relationship issues. Progress to be reviewed at VOPIG in **December 2021.**
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Cheshire & Merseyside

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

RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**		**Update – June 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • A full review of the controls and assurances has been undertaken, recognising the shift in focus following the implementation of the Trust's Our People Plan. The actions have also been reviewed to address the gaps identified. • The reinstatement of Valuing Our People through Inclusion Group will ensure progress against a large number of these actions, and will also provide some accountability through the introducing a mechanism for staff to share their lived experiences, challenge progress of the priorities identified and shape further actions to drive improvement and enhance culture. • It is anticipated the completion of the actions for 2020/21 will further reduce the risk to achievement of the strategic objectives.



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

Risk Description: There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Assurance Committee: Trust Board
Executive Lead: Chief Executive

RISK ID	6	Risk Description	There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Inherent Risk			Risk as at 30/06/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	5	15	3	5	15	3	3	9

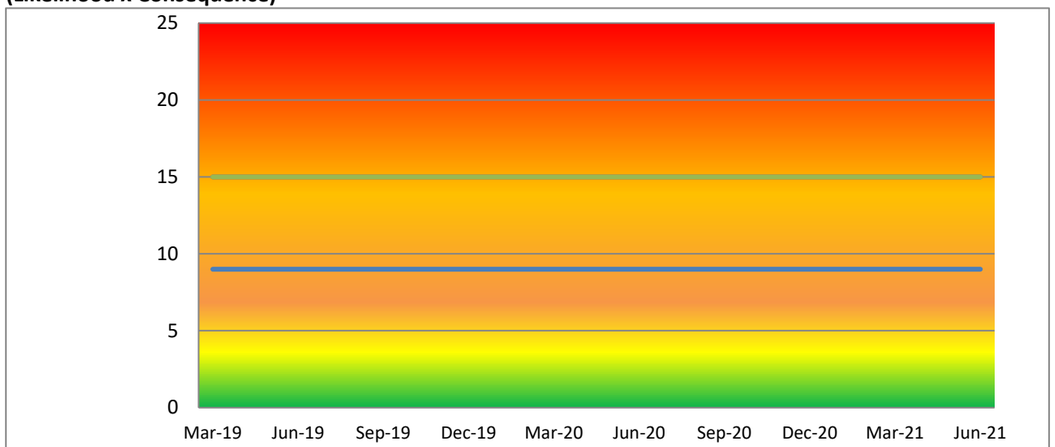
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services **CAUSE** Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire; lack of system-wide workforce planning to address the issues around qualified staff pipeline over the next 5 years and current speciality specific emerging workforce gaps; lack of Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach; challenges around working across two ICS/STP footprints; lack of clarity about additional capital funding support at CMHCP/NHSE/I level to enable emerging scenarios to address sustainability challenges; lack of public engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** Clinical unsustainability due to current and projected workforce gaps as well as activity outweighing capacity; financial unsustainability due to costs significantly outweighing income; poor estate utilisation due to inability to fully reconfigure services; unsustainability of a	1. Robust system governance in place, including: ○ Southport, Formby & West Lancs Programme Board: Shaping Care Together ○ Shaping Care Together operational groups: Delivery Group and Communication & Engagement Group ○ Southport, Formby & West Lancashire Clinical Leaders Group ○ Sefton Provider Alliance ○ Sefton ICP 2. Documentation in place: ○ Finalised and agreed Shaping Care Together (SCT) programme plan for delivery ○ KPMG Case for Change ○ Sefton 2gether ○ West Lancs Building for the Future ○ Acute Sustainability Vision and Design Principles ○ Cheshire and Mersey sustainability and transformation partnership (STP) plan. 3. Whole system engagement from health, social care, voluntary, community and faith sectors (VCFS) partners to be able to address whole system change. 4. Quality and equality impact assessments completed and reviewed before any changes to Trust service provision. 5. System Equality Impact Assessment process established.	1. Clear alignment between Shaping Care Together programme and System Management Board. 2. Lack of established Patient & Public Reference Group.	**LEVEL 1** (Operational Management) 1. Clinical Effectiveness Group 2. Vision 2020 agreed at Board, updated version now in development 3. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 4. Ongoing review and management of 'fragile services'. 5. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board. 6. Patient and public engagement strategy monitored at Programme Board. 7. Equality Impact Assessment outcomes monitored at programme board. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. CEO's reports to Board 2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments 3. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group 4. Programme monitored internally through Trust Board 5. **LEVEL 3** (Independent/Semi-Independent) 1. Southport, Formby & West Lancashire Joint Committee 2. Cheshire & Mersey Health & Care Partnership (CMHCP): Strategic Oversight Group (reporting line) 3. Sefton Provider Alliance. 4. West Lancashire Multi-speciality community partnership (MCP). 5. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations		1. Develop, implement, embed and review Communication and Engagement Strategy and Plan with an effective patient and public forum. **– Action complete and ongoing:** Stakeholder Advisory Group in development 2. Southport, Formby & West Lancashire Clinical Strategy development aligned with organisational strategic directions and emerging solutions from the engagement work **to be complete by end of August 2021.** **Update:** Second round of Models of Care Workshop completed to test out the clinical case for change, further workshops booked in June and new ways to collaborate online being developed 3. Strategic Partnership criteria, principles and framework to be developed in line with engagement approach to ensure transparent and robust partnerships developments that may be required to address sustainability challenges ~~to be complete by end of December 2020. Revised to end of May 21~~ **–Revised to end June 21** revised engagement plan has extended the listening phase 4. Establish Finance and Capital Assurance Group with alignment to the System Management Board **– Update** FCA group established with work near completion on the drivers of deficit. Key risk to progress around the imminent retirement of 3 senior financial leads across the CCG and Trust – DoFs have met and agreed mitigation approach. 5. Complete refresh and review of the Fragile Services across the Trust **Expected Completion end of Q.2** 6. Establishing a 'Fragile Services Group' which would include system stakeholders. 7. Complete a detailed review of the risk register as part of the fragile service in-depth review and pull out the gaps. **Expected completion date Sept 2021**

	standalone organisation to continue to deliver acute services for the population; potential impact on neighbouring organisations and services if core acute services can no longer be delivered by the Trust.			6. NHS England / NHS Improvement 7. CQC 8. CCGs 9. Internal Audit 10. External Audit.		
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve

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

RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 3 x5 = 15 Current 3 x 5 = 15 Target 3 x 3 =9 **(Likelihood x Consequence)**	**1942:** Eradicating Trust deficit by 2023/24 **1688**: Anaesthetic staffing **2161:** Failure to achieve financial improvement trajectories	**Update – July 2021** • The strategic risk and associated linked risks have been reviewed and this remains a high risk. • Public engagement continues with a refreshed microsite and simpler questionnaire. First stage of listening is due for completion in June.



	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21
Target Score	9	9	9	9	9	9	9	9	9	9
Current Score	15	15	15	15	15	15	15	15	15	15
Initial Score	15	15	15	15	15	15	15	15	15	15

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB113/20**	**FOI Exempt**	**NO**
Report Title	**REVIEW OF TRUST'S CORPORATE GOVERNANCE POLICIES**		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To review and approve the Scheme of Reservation and Delegation, Standing Financial Instructions and Standing Orders

Executive Summary

The Trust's Corporate Governance policies which comprise of the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation are reviewed annually in line with best practice. It is noted that any changes to the policies should reflect changes in legislation, directives from regulator or management decisions.

In reviewing the policies, the Audit Committee recommended that the Corporate policies should be made available to all members of the Trust Board and the Trust Senior Management, either electronically, via the intranet or in paper format. It was agreed that an electronic record of confirming receipt of corporate governance policies should be maintained to reflect that relevant parties had seen and read the documents and that this would form part of the annual report of compliance.

The policies were reviewed and endorsed by the Audit Committee subject to the following amendments:

a) Standing Orders

- Page 5 - Minor amendment of the spelling of entrusted.

b) Scheme of Reservation and Delegation:

- 4.2 – it was suggested that the wording be amended to include designate Deputy CEO
- Disaster recovery and Business Continuity Planning (BCP) was included under the Director of Finance's (DoF) portfolio however emergency planning was overseen by a different Executive Director. It was suggested that this was reviewed.
- **10.9.2** – clarity was required around responsibility for performance, improvement, development and assurance as this was the responsibility of the Chief Operating Officer (COO) but overall accountability would lie with the Chief Executive Officer (CEO).
- 10.9.5e – it had been previously agreed to update the wording to exclude 'greater than 20%'
- 10.9.12 – it was noted that if losses and write offs above £49,999 were the responsibility of the Board and not included in the Scheme of Reservation and Delegation the Audit Committee was not able to approve any losses/write offs.
- Removal of 10.9.19b - it was agreed to remove this, and Mr McLuckie would provide feedback at the next Audit Committee meeting around the process for business cases as a more formal process was needed for revenue business cases.
- 10.9.36 – this section must be consistent with the Standing Financial Instructions and Mr McLuckie and Mrs Katema would pick this up via the Information Governance Steering Committee.

c) Standing Financial Instructions:

- 9.1.1 – wording to be expanded to include service commissioners and service providers

- 10.2.2 – It was agreed that this would be removed as it formed part of the Chief Executive's role
- 10.10.1j – to read for settlements over £100,000
- 13.3 – it was agreed that there would be a post completion review of the business case for projects above a set value and this would be conducted by the Business Development and Investment Group (BDIG).
- The EU regulations with regards to contracting and tendering still applied and this section would be updated once guidance had been received.
- 18.10.2 – to be amended to read undertaken
- 21.1 - it was noted that research governance should be included in this section. Mrs Armstrong-Child to review this and provide feedback.
- 21.1 – it was noted that the job titles were defunct, and Mrs Armstrong-Child would forward the updated information to Mrs Katema
- 23.1 – it was noted that the Scheme of Reservation and Delegation provided responsibility and the ability to override instructions to other parties

Recommendation

The Board is asked to **approve** the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Sharon Katema, AD Corporate Governance	Sharon Katema, AD Corporate Governance

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Scheme of Reservation and Delegation

2021/22

A document which outlines the decisions that are reserved for the Board, the authority delegated to employees and committees.

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CONTENTS

1 Introduction

1.1 For effective governance, the Board of Directors must have in place arrangements to ensure that there is clarity about how decisions are made and who makes them.

1.2 No matter how effective the Board of directors may be, it is not possible for it to have hands-on involvement in every area of the organisation's business. An effective Board controls the business but delegates day to day responsibility to executive management. That said, there are a number of matters which are required to be or, in the interests of the company, should only be decided by the Board of directors as a whole. It is incumbent upon the Board to make it clear what these matters reserved for the Board are.

1.3 *The UK Corporate Governance Code* states that *'There should be a formal schedule of matters specifically reserved for [the Board's] decision' and that the annual report should contain a 'high level statement of which types of decisions are to be taken by the Board and which are to be delegated to management.'*

1.3 The Trust's *Standing Orders* (SO4.1) and the *NHS Code of Conduct* and *Code of Accountability* require that the Trust:

- Clearly identifies the types of decisions which are to be reserved for the Board; and
- Ensures that arrangements are in place to enable responsibility for other decisions to be clearly delegated to executive management, officers, and committees.

1.4 The formal *Scheme of Reservation and Delegation* outlines the decisions reserved for the Board and those delegated to Committees and officers.

1.5 The formal *Scheme of Reservation and Delegation* details those decisions which the Board delegates to officers through the Executive Management Structure and to Committees through the Governance Structure.

1.6 The purpose of the *Scheme of Reservation and Delegation* is to empower Directors, and those managers who have been given authority to act on their Directors' behalf, to take appropriate decisions within a robust corporate framework.

1.7 The Board remains accountable for all of its functions even those delegated to Committees, individual Executive Directors and Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2 Role of the Chief Executive

2.1 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to an assurance committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive.

2.2 All powers delegated by the Chief Executive can be re-assumed by the Board should the need arise. As Accountable Officer, the Chief Executive is accountable to the Department of Health for the funds devolved to the Trust.

3 Considerations when Using Delegated Powers

3.1 Powers are delegated to officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

3.2 All those exercising authority delegated by this framework have a duty to observe the wider regulatory framework outlined in the following:

- *Standing Orders*
- *Standing Financial Instructions*
- *Standards of Business Conduct and Managing Conflicts of Interest*
- *Fit and Proper Persons' Regulations*
- *Trust Policies*

3.3 It will be the responsibility of each Executive Director to ensure that those staff members to whom they have delegated authority to exercise decision making powers are capable and competent to do so.

3.4 Although the Trust operates with a number of Directorates, it is vital that Directorate Managers and Service Leads recognise that their area of responsibility is an integral part of the Trust and they should not therefore act in the interests of their Directorate alone but in the interests of the corporate Trust.

4 Absence of Directors or Officers to Whom Powers have been Delegated

4.1 In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless formal acting up arrangements have been put in place or alternative arrangements have been approved by the Board of Directors.

4.2 In the Chief Executive's absence, powers delegated to them may be exercised by the nominated officer acting in their absence usually the Deputy Chief Executive.

4.3 If it becomes clear to the Board of Directors that the Accountable Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accountable Officer, usually the Deputy Chief Executive, pending the Accountable Officer's return. The same applies if, exceptionally, the Accountable Officer plans an absence of more than four weeks during which they cannot be contacted.

5. Scheme of Reservation and Delegation

5.1 Accountability

5.1.1 The *NHS Code of Conduct and Code of Accountability* which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto it. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in paragraphs 5.4 to 5.10 below.

5.1.2 Decisions reserved to the Board generally represent matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions; even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive

information about the exercise of delegated functions to enable it to maintain a monitoring role.

5.2 Duties

5.2.1 It is the Board's duty to:

- act within statutory financial and other constraints.
- be clear what decisions and information are appropriate to the Board of Directors and draw up *Standing Orders*, Standing Financial Instructions and a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these.
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account.
- establish performance and quality measures that maintain the effective use of resources and provide value for money.
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities.
- establish Audit and Remuneration & Nominations Committees based on formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting to the main Board.

5.3 General Enabling Provision

5.3.1 The Board of Directors may determine any matter, (for which it has authority), it wishes in full session within its statutory powers.

5.4 Regulations and Control

The Board of Directors has reserved the following powers unto itself:

5.4.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and *Standing Financial Instructions* for the regulation of its proceedings and business.

5.4.2 Suspend the *Standing Orders*.

5.4.3 Vary or amend the *Standing Orders.*

5.4.4 Note any urgent decisions taken by the Chair and Chief Executive in accordance with SO4.3.

5.4.5 Approval of a *Scheme of Delegation of Powers* from the Board of Directors to Committees and officers.

5.4.6 Receiving the declaration of Board members' interests which may conflict with those of the Trust's business and determining the extent to which that director may remain involved with the matter under consideration.

5.4.7 Approval of the disciplinary procedure for officers of the Trust.

5.4.8 Disciplining Directors who are in breach of statutory requirements of the *Standing Orders or Standing Financial Instructions.*

5.4.9 Approval of arrangements for dealing with complaints.

5.4.10 Adoption of the Trust's organisational structures, processes and procedures to facilitate the discharge of Trust's business and to agree any significant modifications.

5.4.11 Receiving reports from assurance and statutory Committees and to take appropriate action thereon.

5.4.12 Approving the recommendations of the Trust's Committees where the Committees themselves do not have executive powers.

5.4.13 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust.

5.4.14 To approve terms of reference and reporting arrangements of all committees established by the Board of Directors.

5.4.15 Approve arrangements to enable the Trust to discharge its responsibilities as a 'bailer' for patients' property.

5.4.16 Authorise the use of the Trust's Seal in a transparent and honest way to avoid collusion and corruption.

5.4.17 Ratify or otherwise instances of failure to comply with *Standing Orders* brought to the Chief Executive's attention in accordance with *Standing Orders*.

5.4.18 Approve the Trust's Major Incident Plan.

5.5 Appointments

5.5.1 Appoint the Vice Chair of the Board of Directors.

5.5.2 Appoint the Senior Independent Director.

5.5.3 The establishment and disestablishment of committees of the Board.

5.5.4 The appointment of members of committees of the Board.

Dismissals

5.5.5 The dismissal of Executive Directors and the Company Secretary or equivalent.

5.6 Policy Determination

5.6.1 The approval of Human Resources policies incorporating the arrangements for the appointment, dismissal, and remuneration of staff.

5.6.2 The approval of the *Raising Concerns (Whistleblowing) Policy.*

5.6.3 The approval and monitoring of the *Risk Management Strategy.*

5.7 Strategy and Business Plans and Budgets

5.7.1 Definition of the strategic aims and objectives of the Trust.

5.7.2 Approval annually of plans in respect of the application of available financial resources.

5.7.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

5.7.4 Approve the Capital Expenditure Programme.

5.7.5 Approve budgets.

5.7.6 Approve the *Annual Business Plan* for submission to the Independent Regulator, which includes:

- Assumptions on service delivery requirements
- Contract and associated income assumptions
- Expenditure plans and associated assumptions
- Savings plans on revenue
- Capital Expenditure Programmes
- Plans for managing working capital and cash
- Any non-revenue financing arrangements.

5.8 Direct Operational Decisions

5.8.1 Acquisition, disposal or change of use of land and/or buildings.

5.8.2 Approve Private Finance Initiative (PFI) proposals.

5.8.3 The introduction or cessation of any significant action or operation. An activity or operation shall be regarded as significant if it has gross annual income or expenditure in excess of £2.5m.

5.8.4 Approval of any contracts, including purchase orders (other than NHS contracts) amounting to, or likely to amount to, over £500,000 per annum or £2.5m in total.

5.8.5 Approval of individual losses write offs and special payments in line with the Standing Financial Instructions.

5.8.6 Agreeing action on litigation not covered by the NHS Resolution risk pooling schemes.

5.9 Financial and Performance Reporting Arrangements

5.9.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust including but not limited to finance, quality, workforce and operational performance.

5.9.2 Ensure there is oversight, at least in summary form, of monitoring returns required by the Independent Regulators.

5.9.3 Receipt and approval of the Trust's *Annual Report and Annual Accounts*.

5.9.4 Receipt and approval of the *Annual Report and Annual Accounts* for funds held on Trust.

5.9.5 Approval of the opening or closure of any bank or investment account.

5.10 Audit Arrangements

5.10.1 To approve audit arrangements (including arrangements for separate audit funds held on trust) and receive reports of the Audit Committee meetings and take appropriate action:

5.10.2 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.

5.10.3 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

6 Scheme of Reservation and Delegation of Powers

6.1 Delegation to Committees

6.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition, terms of reference and reporting requirements of such committees will be approved by the Board of Directors.

6.1.2 In accordance with the Standing Orders committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

6.2 Delegation to Officers

6.2.1 The *Trust Standing Orders and Standing Financial Instructions* set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors.

6.2.2 The following responsibilities are derived from the *Accountable Officer Memorandum for Chief Executives of NHS Trusts:*

6.2.3 The Accountable Officer has responsibility for ensuring that the Trust carries out its' functions in a way that ensures proper stewardship of public money and assets.

6.2.4 The specific personal responsibilities of a Trust's Accountable Officer:

- The propriety and regularity of the public finances for which they are answerable
- The keeping of proper accounts
- Prudent and economical administration
- The avoidance of waste and extravagance; and
- The efficient and effective use of all the resources in their charge

6.2.5 Accountable Officers must make sure that their arrangements for delegation promote good management and are supported by the necessary staff with an appropriate balance of skills.

6.2.6 This Scheme of Reservation and Delegation only covers matters delegated by the Board to the Chief Executive and by the Chief Executive to the Executive Directors and Company Secretary or equivalent, as well as specific matters set out in the *Standing Orders and Standing Financial Instructions.*

7.0 Relationship of the Scheme of Reservation and Delegation to Organisational Structure

7.1 Each Director is responsible for the delegation within their Directorate and should produce a *Directorate Scheme of Reservation and Delegation* to this effect.

7.2 The *Directorate Scheme of Reservation and Delegation* should be aligned to the *Operational Scheme of Reservation and Delegation* regarding financial matters set out in **10.9.**

8.0 Scheme of Reservation and Delegation aligned with the Trust's Standing Orders

SO Ref	Delegated to	Duties Delegated
1.2.2	Chair	Final authority in the interpretation of the *Standing Orders.*
1.6.1	Chief Executive	Ensure that existing officers and new officers are notified of, and understand, their responsibilities set out in the *Standing Orders and Standing Financial Instructions.*
2.11.3.1	Director of Finance	Responsible for the provision and supervision of financial control and accounting systems.
2.11.6	Chair	Chair all Board meetings (and associated responsibilities).
3.2	Chair	Call meetings of the Board of Directors.
4.3	Chair and Chief Executive in consultation with two Non-Executive Members	Exercise the emergency powers of the Board.
7.4	Company Secretary or equivalent	Maintain a Register of members' and other officers' Interests.
8.1 and 8.3	Company Secretary or equivalent	Keep the Trust Seal in a safe place and maintain a register of sealings.
8.4.1	CEO/ Executive Members / Company Secretary	Approve and sign all documents which will be necessary in legal proceedings.
8.4.3	CEO / Executive Members / Company Secretary	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
9.1	Company Secretary or equivalent	Accept service of all legal proceedings on behalf of the Trust via a *Freedom to Engage Process*
9.2	Company Secretary or equivalent	Authorised to instruct solicitors to advise the Trust or defend the Trust, or in the matter of formal dispute resolution procedures.

9.0 Scheme of Reservation and Delegation aligned with the Standing Financial Instructions

SFI Ref	Delegated to	Duties Delegated
1.5.5	Chief Executive	Ensure all officers, present and future, are notified of, and understand, the *Standing Financial Instructions*.
1.5.6	Director of Finance	Responsible for implementing the Trust's financial policies and co-ordinating corrective action, and ensuring detailed financial procedures and systems are prepared and documented.
1.5.6	Director of Finance	Maintain appropriate systems of financial control and record keeping in line with the requirements of the regulators.
1.5.7	All Directors and officers	Responsible for the security of Trust property, avoiding loss, exercising economy and efficiency in using resources and conforming to *Standing Orders, Standing Financial Instructions* and financial procedures.
2.1	Audit Committee	Provide an independent and objective view on the system of internal control and probity, including assurance statements.
2.1.4	Director of Finance	Ensure adequate internal and external audit services (in accordance with NHS Internal Audit Standards).
3	Director of Finance	Ensure there are adequate counter-fraud and corruption arrangements, including the investigation of cases of fraud or other irregularity.
4	Director of Finance	Ensure adequate security management arrangements.
5.1.1	Chief Executive	Overall responsibility for financial management and the Trust operating within resource limits.
5.1.2	Director of Finance	Submit financial plans and any adjustments to previously agreed financial plans for Board approval.
5.1.2	Director of Finance	Providing financial reports to the regulator.
5.2	Chief Executive	Preparation of Annual Business Plan.
5.2.3	Director of Finance	Monitor performance against plans and budget and submit to Board financial estimates and forecasts.
5.2.6	Director of Finance	Ensure adequate training for budget holders.
5.3.1	Chief Executive	Delegate budget to budget holders.
5.4.1	Director of Finance	Devise and maintain system of budgetary control.

5.4.3	Chief Executive	Cost Improvement Plans and income generation initiatives.
6.1	Director of Finance	Responsible for the preparation and publishing of the Annual Accounts.
6.2	Company Secretary or equivalent	Responsible for the preparation and publishing of the *Annual Report.*
7	Director of Finance	Trust Banking Arrangements.
8	Director of Finance	Income systems including debt recovery.
9.1	Chief Executive	Ensure the Trust enters into appropriate *Service Level Agreements* for the provision of services and report performance against such to the Board.
10.1.2	Remuneration Committee	Agree remuneration and terms of service for Executive Members and Company Secretary or equivalent.
10.4	Director of Finance and Director of HR & OD	Appropriate processing of payroll.
10.5	Director of HR & OD	Responsible for ensuring all officers have a contract of employment.
10.8.7	Director of HR & OD	Approve all decisions to offer an involvement payment to a volunteer or lay member, ensuring records of kept of any such payments.
11.1.1	Chief Executive	Determine, and set out, the level of delegation of non-pay expenditure to budget managers.
11.2.2	Director of Finance	Prompt payment of appropriately authorised supplier accounts and invoices.
11.2.7	Director of Finance	Ensure that arrangements for the financial control and audit of building and engineering contracts comply with best practice.
12	Director of Finance	Advise the Board on borrowing and investment needs and prepare procedural instructions.
13.2.6	Director of Finance	Developing procedures for monitoring the capital programme.
13.7.1	Chief Executive	Overall responsibility for assets.
13.7.2	Director of Finance	Maintenance of asset registers, including the register of properties.
13.7.11	Director of Finance	Calculate and pay capital charges in accordance with the Independent Regulator's requirements.
13.8.4	All Staff	Responsibility for the security of Trust assets including reporting losses in accordance with Trust procedure.
14.6	Director of Finance	System of control over stores and receipt of goods.
15	Director of Finance	Preparing procedures for recording and accounting for losses and special payments and for management of all frauds/thefts.

16.1	Director of Finance	Ensure procurement procedures are compliant with legislation and HMT Managing Public Money.
16.4.1	Chief Executive	Determining exceptional circumstances under which the formal tendering processes can be waived.
16.5.8	Chief Executive	Nomination of an officer to maintain a list of approved firms who may be invited to tender or provide a quote.
16.5.9	Chief Executive	Approve the use of firms not on the list of approved contractors.
16.11.1	Chief Executive	Nominate officers with delegated authority to enter contracts for employment of other officers, to authorise re-grading of staff, and enter into contracts for the employment of agency staff or temporary staff.
16.12.1	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.
16.14.1	Chief Executive	Demonstrate best value for money for all in-house services provided.
16.14.5	Chief Executive	Nominate an officer to oversee and manage each contract on behalf of the Trust.
17.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and procedures on admission.
18.1.7	Director of Finance	Ensure each fund held on Trust is managed appropriately.
19.1	Company Secretary or equivalent	Ensure all staff are aware of the Trust's Policy for the Standard of *Business Conduct and Managing Conflict of Interest Policy.*
19.2	Company Secretary or equivalent	Maintain a Register of Gifts and Hospitality and Sponsorships.
19.3	Company Secretary or equivalent	Fulfil the responsibilities of the Trust's Data Protection Officer
20	Chief Executive/ Company Secretary or equivalent	Ensure the Trust is registered with the Information Commissioner's Office, publishes information in line with the Freedom of Information Act requirements, and maintains and stores information in line with the Data Protection Act.
20.1.2	Director of Finance	Responsible for the accuracy and security of computerised financial data.
21.1.13	Director of HR & OD	Responsible for the accuracy and security of the payroll system.
21.1.14	Director of Finance	Fulfil the responsibilities of the Senior Information Risk Officer on behalf of the Trust.
22.1	Director of Finance	Authorise procurement of IT hardware, software or facility.
22.2	Director of Finance	Ensure adequate arrangements for disaster recovery and business continuity.
22.4	Director of Finance	Ensure new computerised financial systems and amendments to current computerised financial systems are developed in a controlled manner and thoroughly tested prior to implementation.
23	Chief Executive	Responsible for records management including systems for record retention.
24.1.1	Chief	Risk Management Framework

	Executive	
24.4	Company Secretary or equivalent	All insurance arrangements and liaison with NHS Resolution.
24.5.3	Company Secretary or equivalent	Authorise all spend on external legal advice.

10. Operational Scheme of Reservation and Delegation - Introduction

10.1 The Board delegates budgetary responsibility to the Chief Executive who in turn delegates to the Executive Directors.

10.2 The Trust has five Directors, (one of which is the Chief Executive), who are classified as *Executive Directors*. The Director of Human Resources & Organisational Development is a director of the Board but has no voting rights on the Board. The officers are personally responsible to the Chief Executive for their directorate/business units' budgets delegated to them.

10.3 Within the Business Units there is a triumvirate of the Associate Medical Directors, Associate Directors of Operations and Heads of Nursing who are appointed to lead management within their Unit. Ultimate budgetary responsibility, however, remains with the respective Executive Directors.

10.4 Executive Directors can delegate management of specific budgets or elements of budgets to *Budget Managers* (i.e., Deputy Directors or Senior Managers) and these arrangements should be set out in a locally developed *Directorate Scheme of Reservation and Delegation*, which should be effectively maintained and reviewed on an annual basis.

10.5 The *Directorate Scheme of Reservation and Delegation* must be aligned to the *Operational Scheme of Reservation and Delegation* set out in 10.9.

10.6 By exception and in accordance with the locally developed *Directorate Scheme of Reservation and Delegation*, budget managers can delegate management of specific budgets or elements of budgets to *Delegated Budget Managers* (i.e., Department Managers). Budgets must NOT be delegated below this level.

10.7 *Authorised signatories* may be assigned. These are staff members assigned to sign against a budget manager's or delegated budget manager's budget but who are NOT responsible for budget management.

10.8 Locally developed *Directorate Schemes of Delegation* developed within the parameters of this *Operational Scheme of Reservation and Delegation* must be approved by the Chief Executive.

10.9 Operational Scheme of Reservation and Delegation

Delegated Matter:	Authority Delegated to:

1. Management of Revenue Budgets	
a) Responsibility for maintaining compliance with budgetary allocation limits:	
○ For the totality of the Trust	Chief Executive
○ At Directorate level	Executive Director
○ At individual budget level (pay and non-pay)	Budget Manager or Delegated Budget Manager
○ For all central income budgets	Director of Finance
○ For all other areas	Director of Finance
b) Responsibility for transfers between budgets-non pay only	
○ Transfers between budgets within one area of responsibility	Budget Manager
○ Transfers between budgets beyond area of responsibility but within Directorates	Executive Director
○ Transfers between Directorate Allocations	Director of Finance and Chief Executive
2. Budget setting and monitoring	
○ Agreeing budgetary allocations including savings and efficiency targets	Trust Board
○ Monitoring of budgetary performance	Director of Finance
○ Performance delivery framework	Chief Operating Officer escalated to Chief Executive
3. Maintenance/Operation of Bank Accounts	
○ Managing banking arrangements	Director of Finance
○ Operation of bank accounts	Assistant Director of Finance/Deputy Financial Accountant
○ Local commercial bank account. With (BACS and cheque payments)	Director of Finance (managed in accordance Bank mandate limits
○ Setting up direct debits/ Standing orders limits	Assistant Director of Finance/Deputy Financial Accountant (in accordance with Bank mandate)
○ Use of the corporate credit card (held by Director of Finance)	Assistant Director of Finance/Deputy Financial Accountant (subject to card limit)
4. Non-Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services	
a) Requisitions	
○ All requisitions (stock/non-stock) up to £499	Authorised budget signatory
○ All requisitions from £500 to £9,999	Budget Manager or Delegated Budget Manager

○ All requisitions from £10k to £49,999 ○	Executive Director
○ All requisitions from £50k to £499,999 total cost	Chief Executive or Director of Finance
○ Requisitions above £500,000 ** For operational purposes, the Director of Finance has a £10m approval limit on the finance system. However, approvals above the DoF limit of £500k are subject to Board approval.	Trust Board approval
b) Non-pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive or Director of Finance
c) Virements (budget transfers) To manage under and overspends within individual approved budgets, budget holders are permitted to "vire" between budgets based on the following agreement and authorisation	
○ Within a cost centre and budget type (non-pay)	ADO with Finance Business Partner
○ Between pay and non-pay	ADO and responsible Executive Director
○ Between cost centres within the Executive's Portfolio	ADO and responsible Executive Director
○ Between Executive Portfolios	Director of Finance and Chief Executive
d) Recurrent virements (within the same financial year)	
○ Within a cost centre and budget type (non-pay)	ADO and responsible Executive Director
○ All other Virements	Director of Finance and Chief Executive
e) Subsequent variations to contract:	
○ With a value not exceeding £99,999	Executive Director or Director of Finance
○ With a value exceeding £100k up to £0.5m per annum	Director of Finance and Chief Executive
d) Purchase order approval (including pharmacy)	
○ Up to £10,000	Purchasing officer/Senior Pharmacy Technicians
○ Up to £20,000	Senior Purchasing Officer/Deputy
○ Up to £50,000	Pharmacist Deputy Procurement Manager/Chief Pharmacist
○ Up to £100,000	Procurement Manager

○ Over £100,000	Director of Finance
f) Payments	
○ Calculation of payment values based on cash flow forecast	Assistant Director of Finance/Deputy Financial Accountant
○ Approval of payment runs	Assistant Director of Finance/Deputy Financial Accountant Payable Manager
5. Capital Schemes	
a) Approving the annual capital programme	Trust Board (within the Annual Financial Plan)
b) Variation to the total agreed capital programme	Trust Board (subject to compliance with the capital resource limit)
c) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Facilities Manager, Technical Services or Director of Finance
d) Approval of new capital schemes in year	
○ Up to £100,000	Capital Investment Group and then Hospital Management Board
○ Between £100,000 and £250,000	Finance Performance & Investment Committee
○ Above £250,000	Trust Board
e) Variation in value of capital schemes	
○ Variations > 20% but less than £50,000	Capital Investment Group
○ Variations > 20% but less than £250,000	Finance Performance & Investment Committee
○ Variations > 20% and more than £250,000	Trust Board
f) Capital requisition approval limits	
○ Up to £100,000	Financial Accountant/Assistant Director of Finance
○ Up to £500,000	Chief Executive/Director of Finance
○ Over £500,000	Trust Board
g) Estates stage payment certificates	
○ Up to £100,000	Project Scheme Manager
○ Up to £500,000	Chief Executive/Director of Finance
○ Over £500,000	Trust Board
h) Capital contingency authorisation	
○ Up to £50,000	Director of Finance
○ Up to £100,000	Capital Investment Group

○ Up to £250,000	Finance, Performance & Investment Committee
○ Over £250,000	Trust Board
i) Private Finance Initiative (PFI)	
○ Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.	Director of Finance
○ Proposal to use PFI	Trust Board
6. Authority to Obtain Quotation, Tendering and Contract Procedures	
a) Obtaining informal quotations for goods/ services £5,000 - £25,000	Budget Manager
b) Obtaining competitive tenders for goods/ services £25,001 to EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through Contracts Finder or obtained via an accessible framework.*	Executive Director via Procurement
c) Obtaining competitive tenders over EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through OJEU and Contracts Finder or obtained via an accessible framework.*	Executive Director via Procurement
d) Waivering of quotations and tenders subject to SFI 16.8:	
○ Up to £74,999	Director of Finance
○ £75k up to EU thresholds	Director of Finance and Chief Executive
e) Opening electronic and manual/hard tenders	Deputy Director of Finance or Director of Finance and Company Secretary or equivalent
f) Balance sheet	
• Approve payment of PAYE, National Insurance, Superannuation.	
○ Authorisation of NHS Shared Business Services	Assistant Director of Finance/ Deputy Financial Accountant
○ Reconciliation of payments for PAYE, National Insurance and superannuation. Value limited to BACS threshold of £7m	Assistant Director of Finance/ Deputy Financial Accountant
○ Approve payment of payroll pay-overs	Assistant Director of Finance/Deputy Financial Accountant
• Authorisation of payments for court orders, Union fees, Medicash and other payroll deductions. Limit for each individual payover is up to £20,000.	

○ Approve payment of Balance sheet items	Assistant Director of Finance/ Deputy Financial Accountant
Up to £200,000. Payment limit applies to Alliance Healthcare monthly agreement, weekly Liaison Staff flow payroll service and monthly Disbursement service	
g) Approve payment of salary advances	
Up to £10,000	Assistant Director of Finance/Deputy Financial Accountant
7. Charitable Fund approvals	
○ Up to £5,000	Director of Finance
○ Up to £20,000	Chair of Charitable Fund Committee
○ Over £20,000	Trust Board acting as Corporate Trustee
8. Setting of Fees and Charges	
a) Price of NHS Contracts with commissioners	Director of Finance
b) External fees, private patient, overseas visitors, income generation and other patient related services	Director of Finance
c) Fees for items of a sensitive nature	Chief Executive
9. Engagement of personnel not employed by the Trust	
a) Non-Medical Consultancy Staff	Executive Director in line with delegated financial limits
b) Engagement of Trust Solicitors	Company Secretary or equivalent [in their absence, Chief Executive, Director of Finance, Director of Nursing, Midwifery & Therapies and Director of Human Resources & Organisational Development]
c) Engaging of staff not on Trust establishment	Executive Director with Director of Finance and current regulator
10. Agreements / Licenses	
a) Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff	Director of Finance
b) Extensions to existing property and equipment leases	Director of Finance
c) Establishing or terminating leases with annual rental up to £199,999	Director of Finance
d) Establishing or terminating leases with annual value between £200k and £500k	Chief Executive
e) Granting of use of Trust property under license	Director of Finance

11. Condemnations and Disposals	
Items (excluding land and buildings) that are obsolete, redundant, irreparable or cannot be cost effectively repaired:	
a) With current/estimated value <£100 as determined by the budget holder	Delegated budget holder
b) with current/estimated value >£100 up to £4,999 as determined by the budget holder	Executive Director
c) with current/estimated value >£5k as determined by the budget holder	Director of Finance
d) disposal of mechanical and engineering plant and all equipment (subject to estimated income of less than £5k per sale) as determined by the budget holder	Director of Finance
e) disposal of mechanical and engineering plant and all equipment (subject to estimated income exceeding £5k per sale) as determined by budget holder	Director of Finance
12. Losses, Write-offs, and Compensations	
a) Losses (inc. cash) due to theft, fraud, overpayment, and others up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
b) Fruitless payments (including abandoned capital schemes) up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
c) All bad debts and claims abandoned, private patients, overseas visitors and other up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, arson, theft) or other up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
e) Compensation payments made under legal obligation:	

○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
f) Extra contractual payments to contractors up to £49,999:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ £5k to £49,999	Chief Executive or Director of Finance
Ex-gratia payments	
g) Staff and patients for loss of personal effects:	
○ Less than £999	Executive Director
○ £1,000 to £4,999	Director of Finance or Deputy Director of Finance
○ £5,000 to £49,999	Chief Executive or Director of Finance
h) Other:	
○ Less than £4,999	Director of Finance or Deputy Director of Finance
○ More than £5,000	Chief Executive or Director of Finance
13. Reporting of Incidents to the Police	
a) Fraud	Company Secretary or equivalent /Director of Finance/
b) Other	Executive Directors
14. Petty Cash Disbursements (through central cashiers' office at each site)	
○ Expenditure up to £50	Budget Manager or Delegated Budget Manager
15. Implementation of Internal and External Audit Recommendations	Director of Finance/ Company Secretary or equivalent and Lead Executive, monitored by the Audit Committee
16. Maintenance and Update of Trust Financial Procedures	Director of Finance
17. Investment of Funds (including charitable and endowment funds)	
a) Exchequer	Director of Finance
b) Funds held on Trust	Charitable Trustees (Board of Directors
18. External Borrowing	
a) Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Director of Finance
b) Application for draw down of Public Dividend Capital, overdrafts, DH loans and other forms	Trust Board

of External borrowing	
19. Personnel & Pay	
a) Authority to fill funded post to the establishment with permanent staff.	Budget Manager or Delegated Budget Manager for Band 5 nurses- all other posts must have Executive Directors' approval via PAG
b) Authority to alter funded establishment:	
○ Additional staff to the agreed establishment with specifically allocated finance	Executive Director
○ Additional staff to the agreed establishment without specifically allocated finance	Executive Director
c) Additional increments:	
○ The granting of additional increments to staff within budget where acting up	Executive Director
○ The granting of additional increments to staff within budget on permanent basis	Executive Director, on advice from HR and authorisation from Finance
d) Upgrading and re-grading	
○ Approval of market supplements and other variations to terms and conditions	Director of HR and OD
e) Establishments:	
○ Approval of consultants' posts (medical/nursing and other clinical)	Appropriate Executive Director
f) Pay:	
○ Authority to complete standing data forms effecting pay, new starters, variations, and leavers	Budget Manager or Delegated Budget Manager
○ Authority to authorise overtime	Budget Manager or Delegated Budget Manager
○ Authority to authorise travel and subsistence expenditure	Budget Manager or Delegated Budget Manager
○ Authority to agree local pay uplifts including allowances that form part of pay	Director of HR and OD
g) Redundancy/early retirement:	
○ Chief Executive or Executive Director	Remuneration Committee
○ Other member of staff	Chief Executive and Director of HR
20. Authorisation of New Drugs	
Drugs approved by Medicines and Therapeutic Committee	Executive Director and Associate Medical Directors
b) Research/clinical trials:	
○ Ethical approval	Drugs and Therapeutics Group

○ Funding	Executive Director and Associate Medical Directors
21. Authorisation of Sponsorship Deals	Company Secretary or equivalent [In accordance with Standards of Business Conduct and Managing Conflict of Interest Policy]
22. Authorisation of Research Projects	Director of Nursing, Midwifery & Therapies
23. Authorisation of Clinical Trials	Medical Director
24. Governance / Risk Management	
a) Overall responsibility for ensuring that appropriate and effective governance / risk management arrangements, policies, and procedures and meeting structures, including the provision of advice and support to the Trust	Chief Executive
b) Responsibility for ensuring that governance is 'owned by all' and for the identification of leads to co-ordinate governance activities at a local level	Company Secretary or equivalent All Executive Directors/ Associate Medical Directors/ Heads of Nursing and Associate Directors of Operations
25. Insurance Policies	
a) Medico-legal	Company Secretary or equivalent
b) All other insurance	Company Secretary or equivalent
26. Management of Incidents, Serious Untoward Incidents, Complaints, Concerns and Claims	
Incidents	
a) Overall responsibility for ensuring that systems and processes are in place to report and respond to incidents and SUIs	Director of Nursing, Midwifery & Therapies
b) Responsibility for ensuring that incidents and SUIs are investigated thoroughly and in a timely manner and that appropriate remedial action is taken / lessons learnt are shared	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Complaints / Concerns	
a) Overall responsibility for ensuring that all complaints and concerns are dealt with effectively	Director of Nursing, Midwifery & Therapies
b) Responsibility for ensuring complaints relating to a Directorate / Group are investigated thoroughly and within agreed timescales and that appropriate remedial action is taken / lessons learnt are shared	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Claims	

a) Responsibility for ensuring that claims are dealt with effectively and within accordance with agreed procedures and timescales	Company Secretary or equivalent
b) Responsibility for ensuring the provision of timely information to enable the Trust to respond effectively to claims and for ensuring that appropriate remedial action is taken / lessons learnt are shared	Company Secretary or equivalent /All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
27. Media Relations	
a) Within working hours	Head of Communications and Marketing
b) Out of hours	On-Call Director / Head of Communications and Marketing
28. Infectious Diseases and Notifiable Outbreaks	Medical Director or Control of Infection Doctor
29. Facilities for staff not employed by the Trust to gain practice experience and/or to provide services	
a) Clinical staff	Director of Nursing, Midwifery & Therapies or Medical Director
b) Other staff	Appropriate Executive Director
30. Review of Fire Precautions (Nominated Fire Officer)	Director of Finance
31. Review of Medicines Inspectorate regulations	Chief Pharmacist
32. Review of compliance with environmental regulations	Director of Finance
33. Information Governance	Senior Information Risk Officer /Data Protection Officer (DPO)
34. Declarations of Interest Register, including Gifts and Hospitality and Sponsorships	Company Secretary or equivalent
35. Attestation of Sealings in accordance with the Standing Orders, including the keeping of the Register of Sealings	Company Secretary or equivalent
36. Retention of Records	
a) clinical	Chief Operating Officer
b) financial	Director of Finance
c) other	Executive Directors and Company Secretary or equivalent
d) Retention and Management of Policy	Company Secretary or equivalent

37. Caldicott Guardian	Medical Director
38. Audit and Quality, including implementation of NICE guidance	Director of Nursing, Midwifery & Therapies
39. Use of borrowing as financing mechanism	Trust Board
40. Intellectual Property	
a) Approval of license agreements	Chief Executive and Director of Finance
b) Material changes to IP policy	Trust Board
c) Departure from inventor reward in IP policy	Executive Team
41. Compliance with the requirements of the Civil Contingencies Act	Trust Board
42. Approval of creating, selling, or ceasing joint ventures	Trust Board
43. Director of Infection Prevention and Control	Medical Director

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Standing Financial Instructions

2021/22

A document which sets out the arrangements for financial systems and good financial governance within the Trust.

CONTENTS

Definition of Terms

Term	Definition
Accountable Officer	The Chief Executive who is accountable for the public funds entrusted to the Trust in accordance with the Accounting Officer Memorandum.
Board	The Board of Directors comprising the Chair, Executive Directors and Non-Executive Directors collectively as a unitary body.
Budget	A resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;"
Budget holder	The member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chair of the Board of Directors	The person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. This expression will also apply to the Vice-Chair when they are acting in the Chair's absence.
Chief Executive	The chief officer of the Trust.
Committee	A committee appointed by the Board, which reports to the Board.
Company Secretary	The person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with legislation, regulation and national guidance.
Contracting & Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	A member of the Board of Directors;
Director of Finance	The chief finance officer of the Trust.
Funds held on Trust	Those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

Term	Definition
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Motion	A formal proposition to be discussed and voted on during the course of the Board meeting.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	In relation to another person, a member of the same household living together as a family unit;
Standing Financial Instructions	(SFIs) regulate the conduct of the Trusts financial matters
Standing Orders	(SOs) regulate the business conduct of the Trust
Trust	Southport & Ormskirk Hospital NHS Trust

All references to the masculine gender will be deemed to apply equally to the feminine gender when used within these instructions.

SFI.1 Introduction

1.1 Purpose

1.1.1 These Standing Financial Instructions (SFIs) form part of the Trust's Corporate Governance Manual for the purpose of regulating the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Reservation and Delegation (SORD) adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities, which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes.

1.2 Interpretation

1.2.1 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.3 Duty to report non-compliance with the Standing Financial Instructions

1.3.1 All Members of the Board of Directors and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance and Chief Executive as soon as practicable. If the Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for them to recommend action or ratification to the Board.

1.3.2 **Failure to comply with the Standing Financial Instructions is a disciplinary matter, which could result in dismissal.**

1.4 Terminology

1.4.1 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

1.4.2 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust. Including nursing and medical staff and consultants practising on the Trust premises and members of staff of the PFI contractor or trust staff working the contractor under retention of employment model.

1.5 Responsibilities and Delegation

1.5.1 The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy.
b) requiring the submission and approval of budgets within overall income.

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)
d) ensuring appropriate audit provision; and
e) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document

1.5.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the "Scheme of Reservation to the Board of Directors" document. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.5.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources, ensuring that financial obligations and targets are met, and that an effective system of internal control is in place.

1.5.4 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.5.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Trust.

1.5.6 The Director of Finance is responsible for:

a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies; (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes).

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

d) the provision of financial advice to other members of the Board of Directors, and employees.

e) the design, implementation, and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records, and financial reports as the Trust may require for the purpose of carrying out its statutory duties.

1.5.7 All directors and employees, individually and collectively, are responsible for:

a) the security of the property, assets and resources of the Trust.

b) avoiding loss

c) exercising economy and efficiency in the use of resources; and

d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

1.5.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.5.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

SFI.2 Audit

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defines terms of reference and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit and Counter Fraud services.

b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing of significant financial reporting judgements.

c) the monitoring of compliance with Standing Orders and Standing Financial Instructions.

d) reviewing schedules of losses and compensation and making recommendations to the Board of Directors.

e) reviewing the effective implementation of corporate governance measures to enable the Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Annual Governance Statement and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors.

f) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the

organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

2.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter with the Director of Finance in the first instance or at a full meeting of the Board of Directors if still required.

2.1.4 It is the responsibility of the Director of Finance to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the selection process when an audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance in conjunction with the Audit Committee, is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function.

b) ensuring that the internal audit is adequate and meets the NHS Internal Audit Standards.

c) ensuring that the Trust maintains adequate Counter Fraud and Corruption arrangements and deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption.

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

i) a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards,

ii) major internal financial control weaknesses discovered,

iii) progress on the implementation of internal audit recommendations,

iv) progress against plan over the previous year,

v) strategic audit plan,

vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

b) access at all reasonable times to any land, premises, Board Members or employee of the Trust.

c) the production of any cash, stores or other property of the Trust under a Board Member's or employee's control; and

d) explanations concerning any matter under investigation.

2.3 Internal Audit

2.3.1 The NHS Trust Accounting Officer Memorandum requires the Trust to have an internal audit function.

2.3.2 Role of Internal Audit

The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board of Directors, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.

- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control, and governance arrangements.

Internal Audit will review, appraise, and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures.

b) the adequacy and application of financial and other related management controls.

c) the suitability of financial and other related management data.

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) fraud and other offences,

ii) waste, extravagance, inefficient administration,

iii) poor value for money or other causes.

e) Internal Audit shall also independently verify the Board Assurance Framework and other assurance statements in accordance with guidance from the Department of Health.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee, and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a Non-Executive Member of the Trust's Audit Committee.

2.3.6 Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed time-scales specified within the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Audit Committee and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor via the Director of Finance and referred on to the Audit Committee if the issue cannot be resolved.

SFI.3 Fraud, Bribery and Corruption

3.1 The Director of Finance is responsible for overseeing and ensuring compliance with the NHS Contractual requirements for countering fraud, bribery and corruption, as well as any other requirements as may be instructed by NHS Protect periodically.

3.2 All anti-fraud, bribery and corruption services are provided under arrangements proposed by the Director of Finance and approved by the Audit Committee, on behalf of the Board.

3.3 The Director of Finance will appoint a suitable person as Local Counter Fraud Specialist (LCFS). The LCFS shall report to the Director of Finance and shall work with the staff in NHS Protect, in accordance with the Department of Health Fraud and Corruption Manual.

3.4 The Local Counter Fraud Specialist will provide a written report and action plan to the Audit Committee, at least annually, on counter fraud and corruption work within the Trust.

3.5 All Members and officers have a duty to ensure Trust resources are appropriately protected from fraud, bribery, and corruption.

3.6 All members and officers having evidence of, or reason to suspect, financial or other irregularities or impropriety in relation to these instructions to report these suspicions to the Director of Finance, Company Secretary or the LCFS or directly to NHS Protect.

3.7 Under no circumstances will a Member or officer commence any investigation into suspected or alleged crime, as this may compromise any further investigation.

SFI.4 Security Management

4.1 The Director of Finance is responsible for overseeing the provision of security management arrangements compliant with Directions issued by the Secretary of State for Health on NHS security management.

4.2 The Director of Finance will appoint a suitable person as Local Security Management Specialist (LSMS). The LSMS shall report to the Director of Finance.

4.3 The Local Security Management Specialist will produce an annual assessment of security management arrangements. The outcome of the assessment, together with an action plan to address areas of weakness, will be reported to the Audit Committee.

4.4 All members and officers have a responsibility for ensuring that the security of Trust property and safety of staff is not compromised.

SFI.5 Resource Limits, Business Planning, Budgets, Budgetary Control and Monitoring

5.1 Resource Limits

5.1.1 The Trust has a statutory duty not to exceed resource limits. The Chief Executive has overall responsibility for the Trust's activities and is accountable to the Board for ensuring that the Trust stays within resource limits.

5.1.2 The Director of Finance will:

- Provide reports to NHS Improvement in the form required.
- Provide regular financial reports to the Board.
- Ensure money drawn against cash forecasts is required for approved expenditure only, and is drawn only at the time of need, following best practice as set out in 'Cash Management in the NHS'.
- Be responsibility for ensuring that an adequate system for monitoring financial performance is in place to enable the Trust to fulfil its statutory responsibility not to exceed its annual revenue and capital resource limits and cash forecast.

5.2 Preparation and approval of business plans / Service Development Strategy (Local Delivery Plan) and budgets

5.2.1 The Chief Executive will compile and submit to the Board of Directors an Annual Business Plan that takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

a) a statement of the significant assumptions on which the plan is based.

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

5.2.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

a) be in accordance with the aims and objectives set out in the Trust's annual business plan / Service Development Strategy, and the commissioners' local delivery plans.

b) accord with workload and manpower plans.

c) be produced following discussion with appropriate budget holders.

d) be prepared within the limits of available funds.

e) identify potential risks; and

f) be based on reasonable and realistic assumptions.

5.2.3 The Director of Finance shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Director of Finance to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

5.2.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

5.2.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

5.2.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to all budget holders to help them manage successfully.

5.3 Budgetary delegation

5.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) the amount of the budget.

b) the purpose(s) of each budget heading.

c) individual and group responsibilities.

d) authority to exercise virement.

e) achievement of planned levels of service; and

f) the provision of regular reports.

5.3.2 Delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

5.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.4 Budgetary control and reporting

5.4.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) regular financial reports to the Board of Directors in a form approved by the Board of Directors after they have been scrutinised by the Finance, Performance & Investment Committee, containing:

i) income and expenditure to date showing trends and forecast year-end position.

ii) balance sheet, including movements in working capital,

iii) cash flow statement and details of performance within Prudential Borrowing Code.

iii) capital project spend and projected out-turn against plan,

iv) explanations of any material variances from plan/budget.

v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

c) investigation and reporting of variances from financial, and workload budgets.

d) the monitoring of management action to correct variances.

e) arrangements for the authorisation of budget transfers.

f) advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects, and.

g) review of the bases and assumptions used to prepare the budgets.

5.4.2 Each budget holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors.

b) officers shall not exceed the budget limit set.

c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and,

d) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board of Directors.

5.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

5.5 Capital expenditure

5.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 11.) A Project Manager will be identified who will assume responsibility for the budget relating to the scheme.

5.6 Monitoring returns

5.6.1 The Director of Finance is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within the specified time-scales.

SFI.6 Annual Accounts and Reports

6.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice.

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines.

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

The Trust's annual accounts must be audited by an auditor appointed by the Board of Directors on the recommendation of the Audit Committee. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

6.2 The Company Secretary, on behalf of the Trust, will prepare an Annual Report, in accordance with guidelines on local accountability. The Annual Report will be published for access by the public and presented at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

SFI.7 Banking Arrangements

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts, including the provision of banking services and operation of accounts, including the provision and use of procurement or other card services. This advice will

take into account guidance/directions issued by the Department of Health and HM Treasury.

7.1.2 In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Governance Banking Service (GBS) accounts for all banking services.

7.1.3 The Board of Directors shall approve the banking arrangements.

7.2 Commercial Bank and Government Banking Service Accounts

7.2.1 The Director of Finance is responsible for:

a) Commercial bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health.

b) Establishing separate bank accounts for the Trust's non-exchequer funds, including charitable funds.

c) Ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made.

d) Reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn (together with the remedial action taken);

e) Ensuring there are arrangements in place for the monitoring of compliance with the Department of Health guidance on the level of cleared funds; and

f) Ensure that to action transactions governed by the bank mandates there must be two approved signatories who are listed on the mandates and one of the signatories must be the Director of Finance.

7.2.2 All accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

7.3 Banking procedures

7.3.1 The Director of Finance is responsible for ensuring that detailed instructions on the operation of bank and GBS accounts are prepared, which must include:

a) the conditions under which each bank and GBS account is to be operated.

b) the limit to be applied to any overdraft; and

c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

7.3.4 All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Tendering and Review

7.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals not exceeding five years to ensure they reflect best practice and represent best value for money. This will include seeking competitive tenders for the Trust's commercial banking business. This review is not necessary for GBS banking.

7.4.2 The results of the tendering exercise should be reported to the Board of Directors.

SFI.8 Income, Fees and Charges, and Security of Cash, Cheques and other Negotiable Instruments

8.1 Income systems

8.1.1 The Director of Finance is responsible for designing, maintaining, and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

8.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

8.1.3 The Director of Finance is also responsible for ensuring systems are in place for the prompt banking of all monies received.

8.1.4 The Director of Finance will arrange to register with HM Revenues and Customs if required under money laundering legislation.

8.2 Fees and charges other than stated in Trust Contract.

8.2.1 The Trust shall follow the Department of Health's advice in the 'Costing Manual' in setting prices for NHS service agreements.

8.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

8.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

8.2.4 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.3 Debt recovery

8.3.1 The Director of Finance is responsible for ensuring systems are in place for the appropriate and timely recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

8.3.2 Where it is necessary to use the services of a professional debt recovery agency and/or the courts to recover an outstanding debt, the Trust will seek to recover the associated costs from the debtor concerned.

8.3.3 The Director of Finance will confirm any Employee(s) authorised to sign court documentation in relation to the recovery of outstanding debts on behalf of the Trust.

8.3.4 Income not received should be dealt with in accordance with losses procedures.

8.3.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

8.4 Security of cash, cheques, and other negotiable instruments

8.4.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; (No form of receipt which has not been specifically authorised by the Director of Finance should be issued).

b) ordering and securely controlling any such stationery.

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

8.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

8.4.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

8.4.4 All cheques, postal orders, cash etc., shall be banked promptly intact under arrangements approved by the Director of Finance.

8.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be the monitored and recorded within the Finance Department. Any significant trends should be reported to the Director of Finance and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud, bribery or corruption this should be reported in accordance with the Trust's Fraud and Corruption Reporting Arrangements (See Appendices) and the guidance provided by NHS Protect. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Compensations Procedures.

SFI.9 NHS Service Agreements for Provision of Services

9.1 Service Level Agreements

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners and service providers, of NHS services.

9.1.2 All SLAs should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account a number of issues which may involve:

- the standards of service quality expected.
- the relevant national service framework (if any).
- the provision of reliable information on cost and volume of services.
- the NHS National Performance Assessment Framework.
- that SLAs build where appropriate on existing Joint Investment Plans.

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9.1.3 A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

9.1.4 The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.1.5 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

SFI.10 Terms of Service, Allowances and Payment of Members, Officers and Others

10.1 Remuneration and Nominations Committee

10.1.1 In accordance with Standing Orders, the Board shall establish a Remuneration and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The Committee will:

a) agree appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including:

i) all aspects of salary (including any performance-related elements/bonuses)

ii) provisions for other benefits, including pensions and cars

iii) arrangements for termination of employment and other contractual terms

b) agree the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.

c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

10.1.3 The Committee shall be accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Committee meetings should record such decisions.

10.1.4 The Board of Directors will consider proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

10.1.5 The Trust will pay allowances to the Chair and Non-Executive Members of the Board in accordance with instructions issued by the Secretary of State for Health

10.2 Funded establishment

10.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Finance Department is responsible for verifying that funding is available.

10.3 Staff appointments

10.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Executive; and

b) within the limit of their approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

10.3.2 Any exceptions to SFI10.3.1 must be approved in advance and in writing by the Chief Executive.

10.3.3 The Board of Directors will be asked to approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.4 Processing of the payroll

10.4.1 All employees will be paid via bank credit transfer, unless otherwise agreed with the Director of Finance.

10.4.2 The Director of Human Resources and Organisational Development and Organisational Development in conjunction with the Director of Finance is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications.

b) the final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements; and

c) making payment on agreed dates.

10.4.3 The Director of Human Resources and Organisational Development and Organisational Development will issue instructions regarding:

a) verification and documentation of data.

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances.

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

d) security and confidentiality of payroll information.

e) checks to be applied to completed payroll before and after payment.

f) authority to release payroll data under the provisions of the Data Protection Act.

g) methods of payment available to various categories of employee; and

h) pay advances and their recovery.

10.4.3 The Director of Finance will ensure arrangements are in place to issue instructions regarding:

a) procedures for payment by cheque, bank credit, or cash to employees.

b) procedures for the recall of cheques and bank credits.

c) maintenance of regular and independent reconciliation of pay control accounts.

d) separation of duties of preparing records and handling cash; and

e) a system to ensure the recovery from leavers of sums of money, including overpayments, and property due by them to the Trust.

10.4.4 Appropriately nominated managers have delegated responsibility for:

a) processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty.

b) submitting time records, and other notifications in accordance with agreed timetables.

c) completing time records and other notifications in accordance with the Director of Human Resources and Organisational Development and Organisational Development instructions and in the form prescribed by the Associate Director of Human Resources; and

d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination, or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Human Resources and Organisational Development must be informed immediately. In circumstances where fraud might be expected this must be reported to the Director of Finance.

10.4.5 Regardless of the arrangements for providing the payroll service, the Director of Human Resources and Organisational Development in conjunction with the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of employment

10.5.1 The Director of Human Resources and Organisational Development is responsible for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors, and which complies with employment and Health & Safety legislation; and

b) dealing with variations to, or termination of, contracts of employment.

c) ensuring that all volunteers and lay members receive a contract which appropriately reflects their status and entitlement, or not, to pay and/or expenses.

10.6 Expenses

10.6.1 Managers are accountable for approving appropriate expenses incurred in line with the Trust Expenses Policy, Agenda for Change rates and based on their financial delegations set out in the Scheme of Delegation.

10.6.2 Expenses are reimbursed to Employees via payroll.

10.6.3 The expenses system is only for the reimbursement of expenses associated with travel and subsistence and should never be used to reimburse items that should have been and could have been purchased via the Trust's purchasing system.

10.7 Salary Sacrifice Schemes

10.7.1 A salary sacrifice happens when an employee gives up the right to receive part of their cash pay due under their contract of employment. The sacrifice is made in return for the Trust agreeing to provide some form of non-cash benefit (e.g., childcare vouchers,

car, etc). The sacrifice is achieved by varying the employee's terms and conditions of employment relating to pay.

10.7.2 Salary sacrifice is a matter of employment law not tax law. Where an employee agrees to a salary sacrifice in return for a non-cash benefit, they give up their contractual right to future cash remuneration. Therefore, an employee wishing to enter into a salary sacrifice will be required to complete and sign an appropriate amendment to their employment contract.

10.7.3 The Trust may offer employees access to a range of salary sacrifice schemes. Any proposal to offer or withdraw a particular salary sacrifice scheme requires the agreement of both the Director of Finance and the Director of Human Resources and Organisational Development.

10.7.4 All salary sacrifice schemes will be open to all employees of the Trust who hold either a permanent contract or a fixed term contract with more than one year remaining at the point of joining the scheme (not some schemes may be for a longer period than one year and termination before lease end may incur a penalty which is not eligible for salary sacrifice).

10.7.5 For all schemes an employee is required to enter into an arrangement for a finite period of time.

10.7.6 The law governing salary sacrifice schemes does not allow an employee to opt out of most salary sacrifice schemes before the end of the agreed term, other than in the case of an 'unforeseen life changing event'. An employee wishing to opt out of a salary sacrifice agreement before the end of its term will therefore have to sign an appropriate amendment to their employment contract and demonstrate that they meet one of the criteria laid down in law.

10.7.7 Because of the implications for pension entitlement, tax credits and state benefits (e.g., maternity pay, sick pay, etc) employees wishing to enter into a salary sacrifice agreement will be encouraged to seek independent financial advice before entering into the agreement.

10.7.8 A salary sacrifice cannot reduce an employee's gross pay below the national minimum wage. Where this would occur the salary sacrifice will be restricted to an amount that reduces gross pay to the national minimum wage, and any excess will be deducted from net pay. This will be clearly highlighted to an employee before then enter into any agreement.

10.8 Payments to Volunteers and Lay Members

10.8.1 In accordance with tax law, volunteers and lay members can only be reimbursed, without the deduction of income tax and national insurance, for expenses incurred.

10.8.2 Tax law allows for this reimbursement to be:

a) on the basis of actual costs incurred, which require supporting receipts and should be in line with agenda for change expense rates and the Trust's Expenses Policy; or

b) as a round sum allowance which reasonably reflects the costs that are likely to have been incurred and is not time related. Payment of an allowance on a time related basis is deemed to be payment for time and subject to income tax and national insurance.

10.8.3 Where it is proposed to pay a round sum allowance this should be approved in accordance with the process laid down by the Director of Finance, before an offer of payment occurs. As an exception to this, volunteers working at the Trust should submit expenses based on the Trust's Policy for the Recruitment and Management of Volunteers.

10.8.4 All reimbursements or expenses to volunteers and lay members should be made following the submission of a Volunteer Expenses Claims Form in line with the Trust's Policy for the Recruitment and Management of Volunteers.

10.8.5 Where it is proposed to pay a volunteer or lay member an involvement payment this will be classed as income by Her Majesty's Revenue & Customs (HMRC).

10.8.6 Some patient volunteers will be in receipt of state benefits or insurance payments. Job Centre Plus and insurance companies may consider any involvement payments made as income. Any recipients of such payments must be informed of their duty to declare the income in writing to the relevant authorities. Individuals failing to declare this income can put themselves at financial risk, their benefits or insurance payments could be suspended or stopped.

10.8.7 The Director of Human Resources and Organisational Development must approve all decisions to offer an involvement payment to a volunteer or lay member. Decisions to do so must be recorded in writing detailing the payment offer and the requirement upon the recipient to declare this offer in writing.

10.9 Payments to other non-employed officers

10.9.1 Unless specific arrangements have been made, an officer who is not an employee of the Trust (e.g., an officer on secondment to the Trust) should only receive payment from their employing organisation and not from the Trust.

10.9.2 This means that in addition to their employing organisation paying their salary they should also pay any expenses incurred by the office (where appropriate, and agreed, recharging them to the Trust).

10.9.3 The Trust should only pay costs associated with a non-employed officer that are invoiced by their employing organisation.

10.10 Staff Redundancy, Severance, Incentive and Retention Payments

10.10.1 Regulatory/Department of Health and/or HRM Treasury approval is required for all of the following:

a) Redundancies (subject to a capitalised cost de-minimus).

b) Ten or more redundancies, irrespective of capitalised cost.

c) Payments in lieu of notice (subject to a de-minimus).

d) All special severance payments.

e) Financial incentive/retention payments.

f) All novel, contentious or repercussive cases.

g) Change programmes/major restructuring.

h) Voluntary redundancy schemes.

i) Where a decision to terminate employment has been overturned.

j) Where there is a proposed settlement payment of £100,000 (at any grade); and

k) Confidentiality clauses.

10.10.2 Advice should be sought well in advance of the need to undertake any of the above. The timescales required to obtain all necessary approvals may be considerable.

SFI.11 Non-Pay Expenditure

11.1 Delegation of authority

11.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

11.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services should be updated and reviewed on an ongoing basis and annually by the Supplies Department; and

b) where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

c) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, requisitioning, ordering, receipt and payment for goods and services

11.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's legal advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

11.2.2 The Director of Finance shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

11.2.3 The Director of Finance will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed.

b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds.

c) be responsible for the prompt payment of all properly authorised accounts and claims.

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct (including for those invoices below passive approval limits stipulated within SoRD).
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct.
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined.
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained.
- the account is arithmetically correct.
- the account is in order for payment.

iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission

of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

11.2.4 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

a) pre-payments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate.

b) the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments.

e) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold).

e) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.5 Official Orders must:

a) be consecutively numbered.

b) be in a form approved by the Director of Finance.

c) state the Trust terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made.

b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health.

Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars.

ii) conventional hospitality, such as lunches in the course of working visits.

g) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive.

h) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards.

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order".

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds.

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future un-competitive purchase.

j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance.

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.

l) petty cash records are maintained in a form as determined by the Director of Finance; and,

j) orders are not required to be raised for utility bills, NHS Recharges; audit fees and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

11.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and the NHS Trust Capital Accounting Manual. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.2.8 Under no circumstances should goods be ordered through the Trust for personal or private use.

11.3 Joint finance arrangements with local authorities and voluntary bodies

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

SFI.12 External Borrowing and Investments

12.1 Public Dividend Capital

12.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.1.4 All short-term borrowings should be kept to the minimum period possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Board.

12.2 Investment

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

12.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

SFI13 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

13.1 Introduction

13.1.1 Capital commitments typically cover land, buildings, equipment, and IT, including:

a) Authority to spend capital

b) Authority to enter into a leasing agreement

13.1.2 Advice should be sought from the Director of Finance if there is any doubt as to whether the particular proposal is a capital commitment requiring formal approval under SFI 13.

13.1.3 No procurement should be undertaken, or commitment given to purchase from a supplier prior to approval being received. Failure to comply will be a breach of the SFIs.

13.2 Capital investment

13.2.1 Before the start of the financial year the Board is responsible for approving the annual capital plan.

13.2.2 The Director of Finance:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities, based on the Estates Strategy and with the involvement of the Director of Finance, Medical Director, Estates Team and IT Team, and the effect of each proposal upon business plans.

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

c) shall ensure that a Project Board is established for schemes over £500,000.

d) each individual scheme is identified and has a monthly expenditure profile; and

e) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

13.2.3 For capital expenditure proposals the Director of Finance shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

a) that a business case (in line with the guidance contained within the NHS Trust Capital Accounting Manual) is produced setting out:

i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

ii) appropriate project management and control arrangements; and

iii) the involvement of appropriate Trust personnel and external agencies; and

b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

13.2.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “CONCODE/Estatecode” and the NHS Trust Capital Accounting Manual.

13.2.5 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.2.6 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.2.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.2.8 The Director of Finance shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure.

b) authority to proceed to tender.

c) approval to accept a successful tender

13.2.9 The Director of Finance will issue a scheme of delegation for capital investment management in accordance with "CONCODE/Estatecode" and the NHS Trust Capital Accounting Manual guidance and the Trust's Standing Orders.

13.2.10 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.3 Estates Capital Schemes

13.3.1 Capital schemes with a total value of less than £25,000 should be managed according to normal Procurement rules (3 quotes, electronic requisition to the Deputy Financial Accountant, Purchase Order raised)

13.3.2 Capital schemes exceeding £25,000 must follow Procurement rules and go out to formal tender. The Project Manager has the authority to raise stage payment certificates for the main contractor appointed.

13.3.3 The Project Manager has the authority to sign off staged payment certificates for their own schemes up to £100,000. Certificates above this value need to be authorised by the Director of Finance.

13.3.4 Project Managers must engage a Quantity Surveyor where the overall scheme cost (including VAT, equipment, and fees) exceeds £100,000. The role of the Quantity Surveyor is to value stage payments and to challenge and support the value for money of the agreed works costs. In addition, the Quantity Surveyor should aid the Project Manager in forecasting final outturn figures for the scheme.

13.3.5 Where the total value of a capital scheme exceeds £500,000, it is mandatory to appoint a Project Board to oversee the project. The Project Board will include representatives from Estates, Procurement, Finance, Risk, Control of Infection, IT and main contractor.

13.3.6 The Project Manager will report to the Project Board on a regular basis. The Project Manager must provide forecast outturn figures to the Project Board at each meeting. If an overspend is predicted, then this must be brought to the attention of the Capital Investment Group (CIG) and approval sought for further expenditure with an explanation of why additional funds are required.

13.4 IT Capital Schemes

13.4.1 Smaller IT projects can be managed using the current controls in place, i.e., requisition and purchase order authorisation and monthly monitoring with the Deputy Financial Accountant. Projects will have a small, and less formal, Project Board to oversee, control and monitor the project.

13.4.2 Larger IT projects will have a Project Manager who will report to a Project Board on a regular basis. Purchasing controls as above will apply - requisition, purchase order authorisation and monthly monitoring with the Deputy Financial Accountant.

13.4.3 The Project Manager must provide forecast outturn figures to the Project Board at each meeting. If an over-spend is predicted, then this must be brought to the attention of CIG.

13.4.3 A detailed explanation of why additional capital funding is needed must be provided to CIG.

13.5 Medical Equipment

13.5.1 CIG determines the overall capital plan each year which then goes to Trust Board for final approval.

13.5.2 The plan includes an allocation for Medical Equipment. Not all the equipment required in the year will be known at the planning stage and clinical areas need to complete a case of need to apply for capital funding.

13.5.3 The case of need must include the following:

- Details of Medical equipment required, including VAT inclusive cost and copies of any quotes obtained.
- An explanation of why the equipment is required.
- Risk rating
- Clinical impact
- Details of any ongoing revenue consequences

13.5.4 Clinical areas will be invited to present their case at CIG.

13.5.5 Once capital funding has been approved, purchasing will follow the normal controls of an electronic requisition to the Deputy Financial Accountant.

13.5.6 Business cases go to the Business Development & Investment Sub-Committee (BDISC). However, BDISC can only make decisions on revenue expenditure. If an approved business case has an element of capital funding, then it must also go to CIG for the approval of the capital element.

13.6 Private finance

13.6.1 The Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DOH for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

13.7 Asset Registers

13.7.1 The Chief Executive is responsible for the assets of the Trust.

13.7.2 The Director of Finance is responsible for the maintenance of registers of assets and will determine the form of any register and the method of updating and arranging for a physical check of assets against the Asset Register to be conducted over a cycle agreed by the Audit Committee.

13.7.3 The Director of Finance is responsible for ensuring there are processes in place to define the items of equipment which will be recorded on the Asset Register. As a minimum, the minimum data set to be held within these registers shall be as specified in the Group Accounting Manual as issued by the Department of Health & Social Care.

13.7.4 Additions to the fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and capitalised.

13.7.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.7.6 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed Asset Registers.

13.7.7 Land and buildings assets are revalued annually by independent surveyors. Equipment and intangible assets are reviewed for signs of impairment. The value of each asset will be adjusted to current values in accordance with methods specified in the Group Accounting Manual issued by the Department of Health & Social Care.

13.7.8 The value of each asset shall be depreciated using methods and rates as specified in the Group Accounting Manual as issued by the Department of Health & Social Care.

13.7.9 Budget holders will ensure that the respective assets for their areas are physically checked annually.

13.7.10 The Director of Finance is responsible for ensuring there are processes in place to maintain an up to date register of properties owned or leased by the Trust. This should include details of location, tenancy and custody of the deeds and lease documents.

13.7.11 The Director of Finance shall calculate and pay capital charges as specified by the Department of Health & Social Care.

13.8 Security of assets

13.8.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Director of Finance.

13.8.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) recording managerial responsibility for each asset.

b) identification of additions and disposals.

c) identification of all repairs and maintenance expenses.

d) physical security of assets.

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.8.3 All discrepancies revealed by verification of physical assets to fixed Asset Register shall be notified to the Director of Finance.

13.8.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any significant breach of agreed security practices must be reported to the Director of Finance, who will determine the necessary action, including reference to the Local Security Management Specialist.

13.8.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

13.8.6 Where practical, assets should be marked as Trust property.

SFI14 Stock, Stores and Receipt of Goods

14.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store: -

a) Controlled stores - specific areas designated for the holding and control of goods.

b) Wards & departments - goods required for immediate usage to support operational services.

c) Manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

14.2 Such stocks should be kept to a minimum and for:

a) controlled stores and other significant stores (as determined by the Director of Finance) should be subjected to an annual stocktake or perpetual inventory procedures; and

c) valued at the lower of cost and net realisable value.

14.3 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

14.4 The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, the control of any fuel oil of a designated estates manager.

14.5 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as NHS property.

14.6 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses. Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.8 The designated manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also SFI15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.9 Receipt of Goods

14.9.1 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

14.9.2 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

14.9.3 For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The

authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

14.10 Issue of Stocks

14.10.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Director of Finance. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variations.

14.10.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Director of Finance.

SFI.15 Disposals and Condemnations, Insurance, Losses and Special Payments

15.1 Disposals and condemnations

15.1.1 The Director of Finance is responsible for ensuring detailed procedures for the disposal of assets including condemnations, and for the recording and accounting for the disposal.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

b) recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed, or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses

15.2.1 Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Trust or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared to the generality of payments, and special notation in the accounts to bring them to the attention of Parliament.

15.2.2 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. Trust senior

management must comply with NHS contractual requirements in ensuring that suspected fraud, bribery or corruption is reported and investigated by the Trust LCFS.

15.2.3 Managing Public Money defines losses as including, but not limited to:

a) Cash losses (physical loss of cash and its equivalents, e.g., credit cards, electronic transfers.

b) Bookkeeping losses (un-vouched or incompletely vouched payments, including missing items or inexplicable or erroneous debit balances);

c) Exchange rate fluctuations.

d) Losses of pay, allowances and superannuation benefits paid to employees (including: overpayments due to miscalculation, misinterpretation or missing information; unauthorised issue and other causes)

e) Losses arising from overpayments.

f) Losses from failure to make adequate charges.

g) Losses of accountable stores (through fraud, theft, arson, other deliberate act, or other cause)

h) Fruitless payments and constructive losses; and,

i) Claims waived or abandoned (including bad debts).

j) Losses that are subject to insurance cover should be accounted for on a net basis (i.e. after any insurance pay-out).

k) Fruitless payments include payments for rail fares and hotels that are not required but could not be cancelled without a partial or full charge being incurred.

15.2.3 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance who will liaise with the Chief Executive.

15.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud, bribery or corruption or of anomalies which may indicate fraud, bribery or corruption, the Director of Finance must inform their Local Counter Fraud Specialist who will report the incident on the NHS Protect case management database.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Director of Finance must immediately notify:

a) the Board of Directors, and

b) the External Auditor.

c) NHS Protect (if appropriate, through the Local Security Management Specialist).

15.2.6 Within limits delegated by the Department of Health the Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

15.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Director of Finance should consider whether any insurance claim can be made.

15.2.9 The Director of Finance shall maintain a *Losses and Special Payments Register* in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

15.3 Special Payments

15.3.1 The Director of Finance is responsible for ensuring that detailed procedural instructions for the recording and accounting for special payments are prepared and notified to officers.

15.3.2 The Scheme of Delegation sets out delegated approval limits for officers to authorise special payments.

15.3.3 All special severance payments and retention payments require the approval of the Remuneration and Nominations Committee.

15.3.4 Managing Public Money defines special payments as:

a) Extra-contractual payments: payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically, these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's ability to pay, e.g. where the contract provides for arbitration but a settlement is reached without it. A payment made as a result of an arbitration award is contractual.

b) Extra-statutory and extra-regulatory payments are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms;

c) Compensation payments: are made to provide redress for personal injuries (except for payments under the civil service injury benefits scheme), traffic accidents, and damage to property etc., suffered by civil servants or others. They include other payments to those in the public service outside statutory schemes or outside contracts.

d) Special severance payments are paid to employees, contractors and others outside of normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract; and

e) Ex gratia payments: go beyond statutory cover, legal liability, or administrative rules, including: payments made to meet hardship caused by official failure or delay; out of court settlements to avoid legal action on grounds of official inadequacy; and, payments to contractors outside a binding contract, e.g., on grounds of hardship.

15.3.5 The Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS Litigation Authority (NHSLA) in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

15.3.6 The Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:-

- Adopting prudent risk management strategies including continuous review.
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants.
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice.
- Following guidance issued by the NHSLA relating to clinical negligence.
- Achieving the Care Quality Commission Fundamental Standards for Quality and Safety.
- Implementing an effective system of Quality Governance

15.3.7 The Company Secretary or equivalent is responsible for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

SFI.16 Procurement Procedures

16.1 The Procurement Manager is responsible to the Director of Finance for providing management, governance and assurance of the procurement function to ensure:

a) the buying and contract management of goods, services and works is undertaken in accordance with procurement rules and the Standing Orders and Standing Financial Instructions.

b) compliance with HM Treasury Managing Public Money (2015) which requires that all public sector organisations be able to demonstrate value for money for their expenditure.

c) compliance as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions.

16.2 All expenditure is subject to the annual budget allocation and delegated limits set out in the Scheme of Delegation.

16.3 EU Directives Governing Public Procurement

16.3.1 Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Trust.

16.4 Formal Competitive Tendering

16.4.1 The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials, and manufactured articles and
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care).
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

Where the Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

16.4.2 Formal tendering procedures are not required where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation, (this figure to be reviewed annually); or

(b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or

(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.

(e) where the requirement is covered by an existing contract.

(f) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members.

(g) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender.

(h) where specialist expertise is required and is available from only one source.

(i) when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate.

(j) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(k) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(l) where allowed and provided for in the NHS Trust Capital Accounting Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

The Procurement Manager and Head of Technical Services can authorise waiving of competitive procedures up to £25,000. The Director of Finance can authorise waiving of competitive tendering procedures up to £75,000. Waiving of competitive tendering procedures above £75,000 requires sign off by the Chief Executive and Director of Finance.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

16.4.3 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 16.4.2 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

16.4.4 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health and Social Care approval.

16.4.5 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

16.5 Contracting/Tendering Procedure

16.5.1 Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders and be published via EU-Supply website and/or Contracts Finder website.

(ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works (except for maintenance work when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

16.5.2 Expressions of Interest/Invitations to Tender:

Expressions of interest shall be invited via the OJEU website or Contracts Finder, the national advertising portal services for healthcare services should the appropriate value be met or no applicable Framework Agreement is sourced.

Invitations to tender shall be sent out electronically via EU-supply. Evidence of the invitation process and a full audit trail will be held electronically by EU-supply.

16.5.3 Receipt of tenders/tender opening:

EU-supply is a secure website which ensures that tenders are held in safekeeping before being opened. Access is restricted to the Trust Procurement Manager and Deputy Procurement Manager. Tender opening is restricted to the Director of Finance and Deputy Director of Finance. An audit trail is automatically generated which includes date and time of receipt.

16.5.4 Admissibility

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

16.5.5 Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender. All clarification questions received and responses given must be recorded.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members.

(b) understanding of client's needs.

(c) feasibility and credibility of proposed approach.

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded.

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

(c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

16.6 Authorisation of Tenders and Competitive Quotations

16.6.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the Scheme of Reservation and Delegation. These levels of authorisation may be varied or changed. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

16.7 Instances where formal competitive tendering or competitive quotation is not required

16.7.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use an appropriate Framework Agreement for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use an appropriate Framework Agreement the NHS Supply Chain, North of England Commercial Procurement Collaborative or Crown Commercial Services - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

16.8 Private Finance for capital procurement

16.8.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

16.9 Compliance requirements for all contracts

16.9.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the NHS Trust Capital Accounting Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) NHS Standards of Business Conduct

(e) such of the NHS Standard Contract Conditions as are applicable.

(f) contracts with Trusts must be in a form compliant with appropriate NHS guidance.

(g) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(h) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

16.10 Personnel and Agency or Temporary Staff Contracts

16.11.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

16.11 Healthcare Services Agreements

16.12.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by a trust. Such service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

16.12 Disposals

16.13.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer.

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust.

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis.

(d) items arising from works of construction, demolition, or site clearance, which should be dealt with in accordance with the relevant contract.

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

16.13 In-house Services

16.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

16.13.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

16.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

16.13.4 The evaluation team shall make recommendations to the Board of Directors.

16.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

16.14 Applicability of SFIs on Tendering and Contracting to funds held in trust

16.15.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

SFI.17 Patients' Property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

17.3 The Director of Finance must ensure that there is a system for providing detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 A patient's property record, in a form determined by the Director of Finance shall be completed in respect of the following:

a) property handed in for safe custody by any patient (or guardian as appropriate); and

b) property taken into safe custody having been found in the possessions of:

- mentally disordered patients
- confused and/or disorientated patients
- unconscious patients
- patients dying in hospital
- patients found dead on arrival at hospital (property removed by police)

c) A record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

17.5 The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

17.6 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions instructions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

17.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions instructions. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

17.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Director of Finance, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Finance. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

17.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, in which case the property shall be placed in the secure care of the most senior member of nursing staff on duty.

17.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

17.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Trust may be appropriated towards funeral expenses, upon the authorisation of the Director of Finance.

17.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.15 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

SFI.18 Funds Held on Trust (including Charitable Funds)

18.1 Corporate Trustee

18.1.1 The Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. Whilst the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately with full recognition given to its dual accountabilities to the Charity Commission.

18.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

18.1.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

18.1.4 The over-riding principle is that the integrity of each trust must be maintained, and statutory and trust obligations met with adherence to general principles of financial regulatory, prudence and propriety.

18.1.5 Materiality must be assessed separately from exchequer activities and funds.

18.1.6 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board of Directors acting as Trustees.

18.1.7 The Director of Finance shall ensure that each fund which the Trust is responsible for managing is managed appropriately to its purpose and to its requirements and will maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.

18.2 Existing Charitable Funds

18.2.1 The Director of Finance shall arrange for the administration of all existing funds. A “Deed of Establishment” must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

18.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

18.2.3 The Director of Finance shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

18.3 New Charitable Funds

18.3.1 The Director of Finance shall, recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment and must be formally approved by the Charitable Funds Committee.

18.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

18.4 Sources of New Funds

18.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Director of Finance before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Director of Finance.

18.4.2 All gifts, donations, and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Director of Finance via the Cash Office to be banked directly to the Charitable Funds Bank Account.

18.4.3 In respect of Donations, the Director of Finance shall: -

a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These will include: -

i) the identification of the donor's intentions.

ii) where possible, the avoidance of creating excessive numbers of funds.

iii) the avoidance of impossible, undesirable or administratively difficult objects.

iv) sources of immediate further advice; and

v) treatment of offers for personal gifts.

b) provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

18.4.4 In respect of Legacies and Bequests, the Director of Finance shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Director of Finance shall: -

a) provide advice covering any approach regarding: -

i) the wording of wills.

ii) the receipt of funds/other assets from executors.

b) after the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Director of Finance who alone shall be empowered to give an executor a good discharge.

c) where necessary, obtain grant of probate, or make application for grant of letters of administration.

d) be empowered to negotiate arrangements regarding the administration of a Will with executors and to discharge them from their duty; and

e) be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

18.4.5 In respect of fundraising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Director of Finance shall: -

a) advise on the financial implications of any proposal for fund-raising activities.

b) deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations.

c) be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge.

d) be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and

e) be responsible for the appropriate treatment of all funds received from this source.

18.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Director of Finance shall: -

a) be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and

b) be primarily responsible for the appropriate treatment of all funds received from this source.

18.4.7 In respect of Investment Income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest, and other receipts from this source (see below).

18.5 Investment Management

18.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Director of Finance shall be required to provide advice to the Charitable Funds Committee shall include: -

a) the formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value.

b) the appointment of advisers, brokers and, where appropriate, investment fund managers and: -

   i) the Director of Finance shall recommend the terms of such appointments; and for which

   ii) written agreements shall be signed by the Chief Executive.

c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme.

d) the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds.

e) that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines.

f) the review of the performance of brokers and fund managers.

g) the reporting of investment performance.

18.5.2 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment, and accounting for Charitable Funds.

18.6 Expenditure from Charitable Funds

18.6.1 Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee on behalf of the Board of Directors. In so doing the committee shall be aware of the following: -

a) the objects of various funds and the designated objectives.

b) the availability of liquid funds within each trust.

c) the powers of delegation available to commit resources.

d) the avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time.

e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and

f) the definitions of “charitable purposes” as agreed by the Department of Health with the Charity Commission.

18.6.2 Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Delegations; exceptions are as follows: -

a) Any staff salaries/wages costs require Charitable Funds Committee approval

b) No funds are to be “overdrawn” except in the exceptional circumstance that Charitable Funds Committee approval is granted.

18.7 Banking Services

18.7.1 The Director of Finance shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

18.8 Asset Management

18.8.1 Assets in the ownership of or used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure: -

a) that appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account.

b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses.

c) that donated assets received on trust shall be accounted for appropriately.

d) that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

18.9 Reporting

18.9.1 The Director of Finance shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

18.9.2 The Director of Finance shall prepare annual accounts in the required manner, which shall be submitted, to the Board of Directors within agreed timescales.

18.9.3 The Director of Finance shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

18.10 Accounting and Audit

18.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

18.10.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall be undertaken on a basis determined by the Director of Finance.

18.10.3 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them with all necessary information.

18.10.4 The Charitable Funds Committee shall be advised by the Director of Finance on the outcome of the annual audit.

18.11 Taxation and Excise Duty

18.11.1 The Director of Finance shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, budget setting, preparation and submission of the required returns and the recovery of deductions at source.

SFI.19 Acceptance of Gifts and Hospitality and link to Standards of Business Conduct

19.1 The Company Secretary shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

19.2 The Trust's policy follows the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

19.3 All hospitality and gifts accepted by Members and Officers will be recorded by the Company Secretary on the Register of Gifts and Hospitality and will be available for public inspection on request.

SFI.20 Declarations of Interest

20.1 The Company Secretary shall ensure that all staff are made aware of the Trust's Policy for Management of Conflicts of Interest.

20.2 The Trust's policy follows the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

20.3 All interests declared by Members and Officers will be recorded by the Company Secretary on the Register of Interests and will be published at least annually.

SFI.21 Information Governance

21.1 Responsibilities

21.1.1 The Chief Executive is responsible for ensuring that the Trust has registered with the Information Commissioner's Office for compliance with the Data Protection Act 1998 and for ensuring that there are systems in place to ensure that information is published and maintained in accordance with the requirements of the Freedom of Information Act 2000.

21.1.2 The Director of Finance is primarily responsible for the accuracy and security of the financial data of the Trust in accordance with Trust's security retention and data protection policies and ensuring that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks.

21.1.3 The Director of Finance and Director of Human Resources and Organisational Development are jointly responsible for the accuracy and security of the computerised payroll data of the Trust in accordance with Trust security and data protection policies.

21.1.14 The Director of Finance is the Trust Senior Information Risk Officer and as such is responsible for:

a) ensuring that necessary procedures are devised and implemented to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990.

b) ensuring that adequate (reasonable) controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

c) ensuring that contracts for computer services with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission, and storage. The contract should also ensure rights of access for audit purposes.

d) where another health organisation or any other agency provides a computer service, periodically seeking assurances that adequate controls are in operation.

e) advising the Board in relation to information risk and advising how information security risks could impact upon the Trust's operations and strategic goals.

SFI22 Information Technology

22.1 In order to ensure compatibility and compliance with the Trust's IT Strategy, no corporate IT hardware, software, or facility should be procured without the authorisation of the Director of Finance.

22.2 The Director of Finance is the responsible Director for Information Technology within the Trust and is responsible for:

a) ensuring that adequate controls exist for all corporate IT services and systems deployed, to support the business requirements of the Trust.

b) ensuring that systems are in place to ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate business continuity and disaster recovery plans.

c) ensuring that adequate controls exist to enable computer operations to be separated from development, maintenance and amendment.

d) ensuring that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

22.3 In the case of computer systems being proposed all responsible directors and employees will send to the Director of Finance:

a) details of the outline design of the system.

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

22.4 The Director of Finance shall satisfy himself that new computerised financial systems and amendments to current computerised financial and other systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

22.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy himself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy.

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists.

c) Finance staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

22.6 All contractors must agree to, and sign copies of the Trust's IT security policy before accessing any of the Trust's IT systems.

SFI23 Retention of Documents

23.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

23.2 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and/or obsolete services.

23.3 Under the Public Records Act all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

23.4 The Chief Executive is responsible for ensuring systems are in place for maintaining archives for all documents required to be retained under the direction contained in Department of Health guidance, 'Records Management Code of Practice'.

23.5 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises

- Accident and emergency, birth, and all other registers
- Theatre registers and minor operations (and other related) registers.
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint-handling)
- X-ray and imaging reports, output and other images
- Photographs, slides, and other images.
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails
- Computerised records
- Scanned records
- Text messages (both out-going from the NHS and in-coming responses from the patient)

23.6 The documents held in archives shall be capable of retrieval by authorised persons.

23.7 Documents held in accordance with the Records Management Code of Practice shall only be destroyed in line with the Trust's Records Management Policy. Records shall be maintained of documents so destroyed.

SFI.24 Risk Management and Insurance

24.1 Programme of Risk Management

24.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, including risk appetite in accordance with current Department of Health assurance framework requirements, which must be approved by the Board of Directors and monitored by the Audit Committee.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities.

b) engendering among all levels of staff a positive attitude towards the control of risk.

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

d) contingency plans to offset the impact of adverse events.

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured.

g) arrangements to review the Risk Management programme.

24.1.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make an *Annual Governance Statement* within the Annual Report and Accounts as required by current Department of Health guidance.

24.2 Insurance: Risk Pooling Schemes administered by NHSLR

24.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes.

24.2.2 If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.3 Insurance arrangements with commercial insurers

24.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;
(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and
(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

24.4 Arrangements to be followed by the Board of Directors in agreeing Insurance cover

24.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Company Secretary shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

24.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

24.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

24.5 Professional Services: Legal

24.5.1 Legal services are subject to both centralised procurement and efficiency controls.

24.5.2 All spend for external legal advice must be approved by the Company Secretary or equivalent.

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Standing Orders

2021/22

For the regulation of proceedings and business of the Board of Directors

navajo

disability confident EMPLOYER

CONTENTS

Definition of Terms

Term	Definition
Accountable Officer	The Chief Executive who is accountable for the public funds entrusted to the Trust in accordance with the Accounting Officer Memorandum.
Board	The Board of Directors comprising the Chair, Executive Directors and Non-Executive Directors collectively as a unitary body.
Budget	A resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;"
Budget holder	The member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chair of the Board of Directors	The person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. This expression will also apply to the Vice-Chair when they are acting in the Chair's absence.
Chief Executive	The chief officer of the Trust.
Committee	A committee required by statute or locally appointed by the Board, which reports to the Board.
Company Secretary or equivalent	The person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with legislation, regulation and national guidance.
Contracting & Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	A member of the Board of Directors;
Director of Finance	The chief finance officer of the Trust.
Funds held on Trust	Those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Motion	A formal proposition to be discussed and voted on during the course of the Board meeting.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	In relation to another person, a member of the same household living together as a family unit;

Term	Definition
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) regulate the business conduct of the Trust
Scheme of Reservation & Delegation	**(**SORD**)** powers the Board reserves for itself and those delegated to committees and officers
Trust	Southport & Ormskirk Hospital NHS Trust

All references to the masculine gender will be deemed to apply equally to the feminine gender when used within these instructions.

SO1 Introduction

1.1 Purpose

1.1.1 These Standing Orders form a fundamental part of Southport & Ormskirk Hospital NHS Trust (the Trust) Governance Framework. Together with the Standing Financial Instructions and Scheme of Reservation and Delegation, when adhered to they protect the Trust's interests and officers from possible accusation that they have acted improperly.

1.1.2 All Executive and Non-Executive Members and officers should be aware of the existence of these documents and be familiar with their detailed provisions.

1.2 Interpretation

1.2.1 Any queries relating to the contents of these documents should be directed to the Company Secretary or equivalent in the first instance who will be pleased to provide clarification.

1.2.2 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of the Standing Orders (on which he should be advised by the Chief Executive or Company Secretary or equivalent).

1.3 Statutory Framework

1.3.1 Southport & Ormskirk Hospital NHS Trust (the Trust) is a body corporate which was established under the Southport & Ormskirk Hospital NHS Trust *National Health Service Trust* (Establishment) Order 1999 No 890 (the Establishment Order). The principal place of business of the Trust is Southport District General Hospital, Town Lane, Kew, PR8 6PN.

1.3.2 NHS Trusts are governed by statute, latterly the National Health Service Act 2006 and the Health and Social Care Act 2012 and by secondary legislation made under these Acts. The statutory functions are conferred on the Trust by this legislation[1].

1.3.3 As a statutory body the Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care.

1.3.4 The Code of Accountability (See Appendices) requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

1.3.5 The Trust is also bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.4 NHS Framework

1.4.1 In addition to the statutory requirements, the Secretary of State, through the Department of Health issues further directions and guidance. These are normally issued under cover

[1] Older primary legislation includes the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) and the National Health Service Act 1977 (NHS Act 1977) the NHS Act 1999, the Health and Social Care Act 2001.

of a circular or letter.

1.4.2 Other documents of particular significance are:

- *The Code of Practice on Openness in the NHS*
- *The Code of Accountability for NHS Boards*
- *The Code of Conduct for NHS Managers*
- *The Code of Conduct for NHS Boards*
- *Standards of Business Conduct and Managing Conflicts of Interest*
- *The Trust's Code of Conduct*
- *The Fit and Proper Persons' Regulations*
- *The Fit and Proper Persons' Policy and Procedure*

1.5 Delegation of Powers

1.5.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO4) the Trust is given powers to *"make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of (SO5) or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct".* Delegated powers are covered in a separate document (*Scheme of Reservation and Delegation*. This document has effect as if incorporated into the *Standing Orders*.)

1.5.2 Officers only have the authority to exercise powers specifically delegated to them, as summarised in the *Scheme of Reservation & Delegation*.

1.5.3 Wherever a title is used, such as Chief Executive or Director of Finance, in the *Scheme of Delegation* it will be deemed to include officers who have been duly authorised to deputise, in accordance with the principles of SO4.5.

1.6 Standing Orders

1.6.1 It is the duty of the Chief Executive to ensure that existing and new Members and senior officers are notified of and understand their responsibilities within *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation*. Updated copies shall be issued to Members and senior officers. The Company Secretary or equivalent will maintain a record of all recipients.

1.6.2 The *Standing Orders* shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

1.6.3 The Trust Board will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's *Standing Orders and Standing Financial Instructions.*

1.7 Failure to comply with the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation

1.7.1 Failure to comply with these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation* is a disciplinary matter and may result in dismissal in

accordance with the Trust's disciplinary policy. Any financial or other irregularities or impropriety, which involves evidence or suspicion of fraud, bribery or corruption, will be reported to NHS Counter Fraud Authority with a view to a criminal investigation being conducted and potential prosecution being sought.

1.7.2 If for any reason these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation* are not complied with, including the exercise of powers without due authority, all staff have a duty to report full details of the non-compliance to the Chief Executive, Chief Financial Officer or Company Secretary or equivalent as soon as it becomes known.

1.7.3 Full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Audit Committee for it to recommend action or ratification to the Board.

SO2 The Board: Composition, tenure, and role of members

2.1 Composition of the Board

2.1.1 In accordance with *paragraph 3 of Schedule 4 part 1 of the NHS Act 2006* and the *NHS Trusts' Membership and Procedure Regulations 1990* the composition of the Board of the Trust shall be:

- A Non-Executive Chair, appointed by NHS Improvement on behalf of the Secretary of State.
- Up to 5 Non-Executive Members excluding the Chair, appointed by NHS Improvement on behalf of the Secretary of State.
- Up to 5 Executive Members (but not exceeding the non-executive membership) including:
    - the Chief Executive
    - the Director of Finance
    - a medical practitioner
    - a registered nurse or midwife

The Trust shall have not more than 11 and not less than 8 Members (unless otherwise determined by the Secretary of State for Health and Social Care and set out in the Trust's *Establishment Order* or such other communication from the Secretary of State).

2.1.2 The Board operates as a unitary Board, which means that all Board Members, Non-executive and Executive, operate as equal members of a single decision making body and are jointly and severally responsible for the decisions made by the board.

2.2 Terms of Office

2.2.1 The regulations governing the period of tenure of office of the Chair and members and the termination or suspension of office of the Chair and Members are contained in the *NHS Trusts' Membership and Procedure Regulations 1990* (as amended).

2.3 Appointment and Termination of office of the Chair and Non-Executive Members

2.3.1 The Chair and Non-Executive Members shall be appointed for a term of office not exceeding four years as the Secretary of State may specify on making the appointment.

2.3.2 The Chair may resign their office at any time during the period of which they were appointed by giving notice in writing to the Secretary of State. The Non-Executive Members may resign their office at any time during the period of which they were appointed by giving notice in writing to the Chair.

2.3.3 Where during the period of directorship a Non-Executive Member of a Trust is appointed Chair of the Trust, their tenure of office as a Non-Executive Member shall be terminated when their appointment as the Chair takes effect.

2.3.4 If the Secretary of State is of the opinion that it is not in the interests of the health service for a person appointed as a Chair or non-executive Member of an NHS Trust to continue to hold office, they may forthwith terminate the person's tenure of office.

2.3.5 If a Chair or Non-Executive Member of an NHS Trust has not attended a meeting of the Trust for a period of three months, the Secretary of State shall forthwith terminate their tenure of office unless the Secretary of State is satisfied that-

(a) the absence was due to a reasonable cause; and

(b) the Chair or Non-Executive member will be able to attend meetings of the Trust within such period as the Secretary of State considers reasonable.

2.3.6 Where a person has been appointed the Chair or Non-Executive member of an NHS Trust-

(a) if he becomes disqualified for appointment under regulation 11 Membership and Procedure Regulations 1990 (as amended) the appointing authority shall forthwith notify them in writing of such disqualification; or

(b) if it comes to the notice of the appointing authority that at the time of their appointment he was so disqualified it shall forthwith declare that he was not duly appointed and so notify them in writing, and upon receipt of any such notification, their tenure of office, if any, shall be terminated and he shall cease to act as Chair or non-executive member.

2.3.7 If it appears to the Secretary of State that the Chair or Non-Executive member of an NHS Trust has failed to comply with regulation 20 (disclosure etc. on account of pecuniary interest) he may forthwith terminate that person's tenure of office.

2.4 Appointment of the Vice-Chair

2.4.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board may appoint a Non-Executive Member from amongst them to be Vice-Chair. Any appointment will be for such a period, not exceeding the remainder of their term as Non-Executive Member, as they may specify on appointment.

2.4.2 Any Non-Executive Member so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair and the Members of the Trust may thereupon appoint another Non-Executive Member as Vice-Chair in accordance with *Standing Order 3.5.1.*

2.4.3 In order to appoint the Vice-Chair, nominations, including self-nominations, will be invited

within a period of time set by the Board. Where there is more than one nomination a postal vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Directors present, the Board will be requested to confirm that person as Vice-Chair at the meeting in which the nomination is made.

2.4.4 In the event of nominations recording equal number of votes the Chair of the Board will use a casting vote following the postal vote.

2.5 Powers of Vice-Chair

2.5.1 Where the Chair of an NHS Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

2.6 Appointment of the Senior Independent Director

2.6.1 The Board may appoint a Non-Executive Member from amongst them to be Senior Independent Director. Any appointment will be for such a period, not exceeding the remainder of their term as Non-Executive Member, as they may specify on appointment.

2.6.2 Any Non-Executive Member so elected may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair and the Members of the Trust may thereupon appoint another Non-Executive Member as Senior Independent Director in accordance with *Standing Order 2.6.1.*

2.6.3 In order to appoint the Senior Independent Director, nominations, including self-nominations, will be invited within a period of time set by the Board. Where there is more than one nomination a postal vote will be conducted, and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Members present, the Board will be requested to confirm that person as Senior Independent Director at the meeting in which the nomination is made.

2.6.4 In the event of nominations recording equal number of votes the Chair of the Board will use a casting vote following the postal vote.

2.7 Appointment and Termination of Office of the Chief Executive, Other Executive Members and the Company Secretary or equivalent

2.7.1 The Trust shall appoint a Remuneration and Nominations Committee whose members shall be the Chair and Non-Executive Members of the Trust whose function will be to appoint the Chief Executive as a Director of the Trust. The Committee will co-opt the Chief Executive as a member when appointing the Executive Members and Company Secretary or equivalent of the Trust.

2.7.2 If an Executive Member is suspended from their post in the Trust they shall be suspended from performing their function as a Board member for the period of the suspension.

2.7.3 An executive director may resign their office at any time by giving notice in writing to the Chief Executive, who will in turn notify the Remuneration & Nominations Committee. The Chief Executive may resign their office at any time by giving notice in writing to the Chair who will in turn notify the Remuneration & Nominations Committee.

2.8 Appointment of the Deputy Chief Executive

2.8.1 The Chair, Non-Executive Members and Chief Executive may appoint an Executive Member from amongst them to be Deputy Chief Executive. Any appointment will be for such a period, not exceeding their term as an Executive Member.

2.9 Joint Members

2.9.1 Where more than one person is appointed jointly to a post on the Board those persons will be appointed as a Joint Member and will count for the purpose of *SO3.1* as one person.

2.9.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) either both of those persons may attend or take part in meeting of the Board.

(b) if both are present at a meeting, they should cast one vote if they agree.

(c) in the case of disagreements, no vote should be cast.

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of *SO3.11 Quorum*.

2.10 Disqualification as a Member

2.10.1 The following may not become or continue as a Member:

(a) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

(b) A person who has been the subject of a bankruptcy restriction order or interim order.

(c) Anyone who has been dismissed (except by redundancy) by any NHS body.

(d) Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986.

(e) Anyone who has been removed from Trusteeship of a charity.

(f) Anyone who has failed the fit and proper persons test as set out in Schedule 5 of the Fit and Proper Persons' Regulations

2.11 Role of Members

2.11.1 The Board will function as a unitary Board, Non-Executive and Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Chief Executive

2.11.2.1 The Chief Executive will be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and will be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the *Accountable Officer Memorandum for Trust Chief Executives.*

2.11.2 Director of Finance

2.11.3.1 The Director of Finance will be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she is the Chief Financial Officer for the Trust and will be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.11.3 Executive Members

2.11.4.1Executive Members will exercise their authority within the terms of these *Standing Orders and Standing Financial Instructions and Scheme of Reservation and Delegation*.

2.11.4 Non-Executive Members

2.11.5.1The Non-Executive Members will not be granted nor will they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of the Board or when chairing a committee of the Trust which has delegated powers.

2.11.5 Chair

2.11.5.1 The Chair is responsible for the operation of the Board and will chair all Board meetings, when present.

2.11.5.2 The Chair has certain delegated executive powers.

2.11.5.3 The Chair must comply with their terms of appointment and with *these Standing Orders.*

2.11.5.4 The Chair will liaise with NHS Improvement over the appointment of Non-Executive Members and once appointed will take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

2.11.6.5 The Chair will work in close harmony with the Chief Executive and will ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.11.6 Non-Voting Members

2.11.7.1 Non-voting members may exercise their authority within the terms of these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.* Non-voting members may participate in discussions at Board but do not have voting rights. They may, however, have voting rights on any of the Trust's statutory or assurance committees of which they are members

2.11.8 Company Secretary or equivalent

2.11.8.1 The Company Secretary or equivalent is accountable to the Board, Chair and Chief Executive for leading the highest standards of corporate governance as the custodian of these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation*.

2.11.8.2 The Company Secretary or equivalent acts as the '*conscience*' of the Board by promoting transparency, probity and accountability in the conduct of the Trust's business.

2.11.8.3 The Company Secretary or equivalent is responsible for ensuring that the Trust operates in accordance with statutory and regulatory provisions, ensuring that the Trust is legally constituted and operates within its authority as a sovereign body.

2.12 Lead Roles for Board Members

2.12.1 The Chair will ensure that the designation of lead roles or appointments of Board Members as required by any statutory or regulatory guidance will be made in accordance with relevant requirements.

2.13 The Corporate Role of the Board

2.13.1 The Board is the senior decision-making authority in the Trust; it provides strategic leadership to the Trust and in support of that:

- Sets the overall direction of the Trust, within the context of NHS mandate, by setting strategic objectives
- Approves the Annual Business Plan (Operational Plan), which is designed to support the achievement of strategic objectives and monitors the Trust's performance against them
- Holds the Executive Team to account for the performance and running of the Trust (including compliance with legislative and regulatory requirements)
- Determines a *Scheme of Reservation and Delegation*
- Ensures the highest standards of corporate governance and personal conduct
- Ensures the highest standards of quality care are delivered
- Provides effective financial stewardship
- Promotes effective dialogue with external and internal stakeholders

2.13.2 All business of the Trust is conducted in the name of the Board.

2.13.3 The functions conferred upon the Board will be exercised by the Board meeting in public session, except as otherwise provided for in *SO3.1.*

2.14 Schedule of Matters Reserved to the Board and Scheme of Delegation

2.14.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the *Schedule of Matters Reserved to the Board* and shall have effect as if incorporated into the *Standing Orders*. Those powers which it has delegated to officers and other bodies are contained in the *Scheme of Delegation* and shall have effect as if incorporated into the *Standing Orders.*

SO3 Meetings of the Board

3.1 Openness

3.1.1 All ordinary meetings of the Board are open meetings and members of the public can attend these meetings. As such they are considered to be meetings where the public may observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate. Contributions from the public at such meetings can be considered at the discretion of the Chair.

3.1.2 Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. The exemptions set out within the *Freedom of Information Act 2000* will be used as the basis for deciding which items may be excluded from discussion in public. Such items will be business that:-

- relates to a member of staff;
- relates to a patient;

- are still in draft form and will at a future date feature on the agenda of the Board meeting held in public.
- would commercially disadvantage the Trust if discussed in public; or,
- would be detrimental to the operation of the Trust if discussed in public.

3.1.3 Members and officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked *'In Confidence'* or minutes headed *'Items Taken in Private'* outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.1.4 Before each meeting of the Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be published on the Trust's website *at least three clear days before the meeting* (required by the *Public Bodies (Admission to Meetings) Act 1960 SI(4)(a).*

3.1.5 Admission of the Public and the Media – The public and representatives of the Media shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Administration to Meetings) Act 1960).

3.1.6 The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the Media such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" *(Section 1 (8) Public Bodies (Administration to Meetings Act 1960).*

3.1.7 Nothing in the *Standing Orders* shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.2 Calling Meetings

3.2.1 The ordinary meetings of the Board shall be held at regular intervals unless the Board shall by resolution otherwise decide. There will be *no fewer than six meetings per year.*

3.2.2 The Chair may call a meeting of the Board at any time by appropriate means, including but not limited to, by email.

3.2.3 One third or more Members of the Board may requisition a meeting by giving written notice to the Company Secretary or equivalent specifying the business to be carried out. If the Chairman refuses, or fails to call a meeting within seven days of a requisition being presented, the Members signing the requisition may forthwith call a meeting.

3.3 Notice of Meetings

3.3.1 Regular Meetings of the Board

3.3.1.1 The Company Secretary or equivalent will send a written notice of the dates, times and locations of meetings to all Board Members with as much notice as possible but not less than fourteen days' notice. Failure to service such notice on more than three Members will invalidate the meeting. A notice shall be presumed to have been served at the time one day after posting or emailing.

3.3.2 Exceptional Meetings of the Board

3.3.2.1 In exceptional circumstances, where there is an urgent need to call a meeting, the Chair may authorise calling a meeting with less than fourteen days' notice and in such circumstances as much notice as possible will be given of the meeting to each Member.

3.3.2.2 Lack of service of the notice on any Member shall not affect the validity of a meeting being called in exceptional circumstances. Failure to serve notice on more than three Members will invalidate the meeting.

3.3.3 Meetings Called By Members

3.3.3.1 In the case of a meeting called by Members in the event the Chair has not called the meeting, the notice shall be signed by those Members and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Public Notice of Meetings

3.3.4.1 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be published on the Trust's website at least three clear days before the meeting. (Required under the *Public Bodies' Admission to Meetings Act 1960 S.I. (4) (a).*

3.4 Agendas and Petitions

3.4.1 Agendas and supporting papers will be sent to members at least 6 days before the meeting and no later than 3 clear days before the meeting, except in an exceptional circumstances and with express agreement of the Chair.

3.4.2 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.4.3 In accordance with SO3.4.2 the following items may appear on every agenda for a meeting of the Board:

- Minutes of the previous meeting
- Matters arising
- Declaration of Interests
- Chief Executive's Report
- Reports from Board Committees
- Trust's Risk Register

3.4.4 A Member desiring a matter to be included on an agenda shall make their request in writing to the Chair, via the Company Secretary or equivalent at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair who will approve the agenda 9 clear days before the meeting.

3.4.5 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.5 Notice of Motions

3.5.1 Subject to the provision of *SO 3.7(Motions*: Procedure at and during a meeting) and SO 3.8 (Motions to rescind a resolution) a Member of the Board wishing to move a motion shall send a written notice to the Company Secretary or equivalent at least 10 clear days before the meeting who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The Company Secretary or equivalent shall include on the agenda all notices received that are in order and permissible under governing regulations. This *Standing Order* shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of *SO3.7 'Motions: Procedure at and during a meeting', a Member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.'*

3.7 Motions: at and during a meeting

3.7.1 **Who may propose?**

3.7.1.1 A motion may be proposed by the Chair of the meeting or any Member present. It must also be seconded by another Member.

3.7.2 **Procedure**

3.7.2.1 When a motion is under discussion or immediately prior to discussion it will be open to a Member to:

i) amend the motion;

ii) adjourn the discussion;

iii) request that the meeting proceed to the next item of business*;

iv) that the question being considering should be now put*;

v) the appointment of an 'ad hoc' Committee to deal with the specific item of business;

vi) a motion under *Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960* resolving to exclude the public, including the press.

** Motions may only be put by a member who has not previously taken part in the debate.*

3.7.2.2 The mover of a motion shall have the right to reply at the close of any discussion on the motion or any amendment thereto.

3.7.2.3 If a motion is to proceed to the next item of business or that the question should be now put, once the mover of the motion has had the right to reply, the matter should then be put to the vote.

3.7.2.4 A motion or an amendment to a motion may be withdrawn.

3.7.2.5 No amendment to the motion will be admitted if, in the opinion of the Chair, the amendment negates the substance of the motion.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member who gives it and also the signature of three other Members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Board it shall not be competent for any Member other than the Chair to propose a motion to the same effect within six months. This *Standing Order* shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if there is one and he is present, shall preside.

3.9.2 If the Chair and Vice-Chair are both absent such Non-Executive Member as the Chair has previously designated may preside, or in the absence of such designation the Members present shall choose a Non-Executive Director to preside.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matters, including their interpretation of the Standing Orders and Standing Financial Instructions, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting of the Board *unless one third of the whole number of voting Members are present* including *at least two Executive Members and two Non-Executive Members.* Members attending via video or telephone conferencing will be considered present and count towards the quorum.

3.11.2 An officer in attendance for an Executive Member but without formal acting up status may not count towards the quorum.

3.11.3 If the Chair or a Member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest *SO7* he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.11.4 The above requirement for *at least two Executive Members to form part of the quorum shall not apply where the Executive Members are excluded from a meeting due to a conflict of interests.*

3.11.5 In the case of joint members the presence of one or both Members will count as one Member towards the quorum.

3.12 Voting

3.12.1 Save as provided under *SO3.15 Suspension of Standing Orders* - If a consensus decision is not reached at a meeting then the question shall be determined by a majority of the votes of the Members present. Members attending via telephone or video conferencing are considered present and therefore have a vote.

3.12.2 In the case of any equality of votes, the Chair presiding the meeting shall have a second and casting vote.

3.12.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members present so request. Members attending via telephone or video conferencing will cast their vote verbally (such vote to be recorded in the minutes).

3.12.4 If at least one-third of the Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member present voted or abstained.

3.12.5 If a Member so requests, their vote shall be recorded by name.

3.12.6 In no circumstances may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.7 An officer who has been appointed formally by the Board to act up for an Executive Member during a period of incapacity or temporarily to fill an Executive Member vacancy, shall be entitled to exercise the voting rights of the Executive Member. An officer attending the Board to represent an Executive Member without formal acting up status may not exercise the voting rights of the Executive Member. An officer's status when attending a meeting shall be recorded in the minutes.

3.12.8 Non-voting Members are able to take part within Board discussions and provide their opinion but do not have voting rights.

3.12.9 In the case of joint members if both are present they should cast one vote if they are in agreement. In the case of disagreements no vote should be cast.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be approved by the Board.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded as actioned at the next meeting.

3.13.3 The names of the Chair and Members present and those in attendance at the meetings shall be recorded.

3.13.4 Any matters arising from the Minutes shall be subject to discussion at Chair's discretion. Where providing a record of a public meeting the minutes shall be made available to the public *(required by Code of Practice on Openness in the NHS).*

3.14 Annual General Meeting

3.14.1 The Trust will publicise and hold an Annual General Meeting in accordance with the *NHS Trusts' (Public Meetings) Regulations 1991 (SI(1991)482*). The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the Standing Orders may be suspended at any meeting, *provided that at least two-thirds of the Board are present, including one Executive Member and one Non-Executive Member*, and that a majority of those present vote in favour of suspension.

- A decision to suspend SOs shall be recorded in the minutes of the meeting.
- A separate record of matters discussed during the suspension of SOs shall be made

and shall be available to the Directors.

- No formal business may be transacted while SOs are suspended.
- The Audit Committee shall review every decision to suspend SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 These Standing Orders shall be amended only if:

- *a notice of motion under SO 3.5 has been given; and*
- *upon recommendation of the Chair or Chief Executive* included on the agenda for the meeting; and
- no fewer than half the total of the Trust's Non-Executive Members vote in favour of amendment; and
- at least two-thirds of the Members were present at the meeting where the variation or amendment was being discussed; and that at least half of the Board's Non-Executive Members vote in favour of the amendment; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

SO4 Arrangements for the exercise of functions by delegation

4.1 Introduction

4.1.1 Subject to the *Scheme of Reservation and Delegation*, and such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO5 or by a Member or an officer of the Trust. In each case such delegation will be subject to such restrictions and conditions as the Board thinks fit.

4.1.2 *Schedule 4 of the NHS Act 2006* allows for regulations to provide for the functions of Trusts to be carried out for the Trust by third parties in the following ways:

(i) by another Trust;

(ii) jointly with one or more NHS Trust;

(iii) by arrangement with the appropriate Trust, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements under s63 (1) of the *Health Services and Public Health Act 196*8, jointly with one or more Trusts.

4.1.3 Where a function is delegated by these regulations to another NHS body, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or officers, the Trust delegating the function retains full responsibility.

4.2 Framework for Delegation of Board Authority

4.2.1 The ultimate responsibility for decisions taken under delegated powers remains with the Board, and the Trust must ensure that due regard has been given and can clearly demonstrate it has not come to an unreasonable decision.

4.2.2 To avoid possible allegations of unlawful exercise of discretion by the Board, a committee or Member acting under delegated powers should record in writing the matters which have

been taken into account in reaching that decision, especially where significant sums or legal commitments are involved.

4.2.3 In making any decisions under delegated powers, a committee or Member must have due regard to the established policies of the Trust and not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Board at the earliest opportunity.

4.2.4 In exercising any delegated power a committee or Member must comply with any statutory provisions or requirements.

4.2.5 In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board.

4.2.6 The Board may require any particular delegated matter to be referred back to them for a decision and reserves the ability to, at any time, withdraw a function, duty or power it has delegated and then to exercise the function, duty or power itself or to delegate it elsewhere.

4.3 Emergency Powers and Urgent Decisions

4.3.1 The powers which the Board has retained to itself within these *Standing Orders* may in an emergency or when there is a need for an urgent decision be exercised by the Chair and the Chief Executive after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Board for ratification.

4.4 Delegation to Committees

4.4.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, sub-committees or joint committees which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, sub-committees or joint committees, and their specific executive powers shall be approved by the Board, or in respect of sub-committees by the appropriate Board Committee.

4.5 Delegation to Officers

4.5.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee, sub-committee or joint committee shall be exercised on behalf of the Board by the Chief Executive.

4.5.2 The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

4.5.3 The Chief Executive shall prepare a Scheme of Delegation (as detailed within the *Scheme of Reservation and Delegation*, identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.

4.5.4 The Chief Executive may periodically propose amendment to the *Scheme of Reservation and Delegation* which shall be considered and approved by the Board as indicated above.

4.5.5 In delegating to employees reference will be made to job titles rather than individuals. The delegation will cover the substantive post-holder, any interim employee appointed to the post or any employee formally deputising into the post during a period of absence of the substantive post holder or to cover a vacant post. This is subject to the interim or deputising arrangements being formally documented and signed off by the appropriate Director with records retained for audit purposes.

4.5.6 The Trust does not have statutory authority to delegate powers to officers who are not employees other than Non-Executive Members.

4.5.7 Where a power has not been specifically delegated to an officer under the procedures set out in *SO4.5* they have no authority under these *Standing Orders, Standing Financial Instructions or the Scheme of Delegation* to exercise that power. In the event of powers being exercised without due authority refer to *SO1.7*.

4.5.8 Nothing in the *Scheme of Delegation* will impair the discharge of the direct accountability to the Board of the Director of Finance, in their capacity as Chief Financial Officer, and the Company Secretary or equivalent to provide information and advise the Board in accordance with statutory or other requirements. Outside of these statutory requirements the Chief Financial Officer is accountable to the Chief Executive for operational matters.

4.5.9 The arrangements made by the Board as set out in the *Scheme of Reservation and Delegation* shall have effect as if incorporated in these *Standing Orders.*

4.6 Ability to delegate delegated functions, duties and powers

4.6.1 The Board, Committees and officers may not delegate functions, duties or powers that have been delegated to them under *SO4.4 and SO4.5* unless specifically authorised to do so as part of the delegation of that function, duty or power.

4.6.2 Where the *Scheme of Delegation* refers to non-post specific terminology the Director(s) identified in accordance with 4.5.2 may prepare an operating framework that will identify their proposed downward delegation to specific post(s) within their area of responsibility.

SO5 Appointment of Committees and Sub-committees

5.1 Appointment of Committees

5.1.1 Subject to such directions (and to guidance issued by the Department of Health) as may be given by the Secretary of State, the Board may appoint committees of the Board. The Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

5.2 Joint Committees

5.2.1 Joint committees may be appointed by the Board by joining together with one or more other Trusts or health service bodies, consisting wholly or partly of the Chair and Members of the Board or other health service bodies or wholly of persons who are not members of the Board or other health service bodies in question.

5.2.2 A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Secretary of State or the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

5.3.1 The Standing Orders and Standing Financial Instructions of the Trust apply to the

meetings of any committees or sub-committee established by the Trust. The term "*Chair*" is to be read as a reference to the Chair of other committee and the term "*member*" is to be read as a reference to a member of other committee, as the context permits.

5.3.2 There is no requirement to hold meetings of committees established by the Board in public.

5.3.3 The *Standing Orders and Standing Financial Instructions* of the Trust apply to the meetings of any joint committees where alternative governance arrangements have not been established and agreed by the Board.

5.4 Terms of Reference

5.4.1 Each committee or sub-committee shall have terms of reference clearly stating any delegated authority and be subject to conditions (such as reporting to the Board) as the Board shall decide. Such terms of reference shall be in accordance with any legislation and regulation or direction issued by the Secretary of State.

5.4.2 Where committees are authorised to establish sub-committees the committee will also have the authority to determine the terms of reference of each sub-committee established within its delegated authority, taking into account any conditions as the Board shall decide, legislation or direction issued by the Secretary of State.

5.4.3 Such terms of reference shall have effect as if incorporated into the *Standing Orders*.

5.5 Delegation of powers by Committees to Sub-Committees

5.5.1 Committees may establish sub-committees but may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 Approval of Appointments to Committees

5.6.1 The Board shall approve the appointments to each of the committees which it has formally constituted.

5.6.2 Where committees are authorised to establish sub-committees the committee will also have the authority to determine the membership of the sub-committee it establishes.

5.6.3 Where the Board determines and regulations permit, that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State.

5.6.4 The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6.5 The appointment of Board members to the committees and sub-committees of the Trust comes to an end on the termination of their term of office as Board members.

5.7 Appointments for Statutory Functions

5.7.1 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

5.8 Committees Established by the Board

5.8.1 The committees established by statute are:

5.8.2 Audit Committee

5.8.2.1 In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Board and reviewed on a periodic basis.

5.8.2.2 The Board will appoint a minimum of three Non-Executive Members at least one of which must have significant, recent and relevant financial experience.

5.8.3 Remuneration and Nominations Committee

5.8.3.1 In line with the requirements of the NHS Codes of Conduct and Accountability and the Higgs Report a Remuneration and Nominations Committee will be established and constituted.

5.8.3.2 The Board has determined that the Remuneration & Nominations Committee will comprise all of the Non-Executive Members and as such will have fully delegated powers from the Board.

5.8.3.3 The purpose of the Committee will be to decide appropriate remuneration and terms of service for the Chief Executive and other Executive Members and the Company Secretary or equivalent including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms;
- ensure a formal, rigorous and transparent procedure for Board appointments is followed;
- consider Board succession planning; and
- review Board composition.

5.8.4 Charitable Funds Committee

5.8.4.1 In line with its role as a corporate Trustee for any funds held in Trust, either as charitable or non-charitable funds, the Trust Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The Committees appointed by the Board as assurance committees are:

5.8.5 Finance, Performance & Investment Committee

5.8.5.1 The Committee is established on behalf of the Board to provide oversight, challenge and assurance regarding the use of resources and sustainability. The Committee will be chaired by a Non-Executive Member.

5.8.6 Quality & Safety Committee

5.8.6.1 The Committee is established to provide the Board with assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on quality, risk management and mortality and morbidity. The Committee will be chaired by a Non-Executive Member.

5.8.7 Workforce Committee

5.8.7.1 The committee is established to provide assurance that the Workforce and Organisational Development Strategies are effectively developed and implemented and that staff are competent and confident to meet the requirements of the Trust workforce. The Committee will be chaired by a Non-Executive Member.

5.9 Other Committees

5.9.1 The Board may also establish other committees as required to discharge the Trust's responsibilities.

5.10 Confidentiality

5.10.1 A member or person in attendance at a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.10.2 A Member of the Board or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee resolves that it is confidential.

SO6 Overlap with other policy statements, procedures, regulations and standing financial instructions.

6.1 Policy Statements: General Principles

6.1.1 The Board will put in place arrangements for agreeing and approving policy statements and procedures for the Trust.

6.1.2 The decisions to approve such policies and procedures will be recorded in the minutes of the Board or committee and thereafter such policy statements will be deemed to be an integral part of these Standing Orders and the Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding SO6.1 the following policy statements shall have effect as if incorporated in these Standing Orders:

- Standards of Business Conduct and Managing Conflicts of Interest
- Anti-fraud, Bribery and Corruption Policy
- Staff Disciplinary and Appeals Policy

6.3 Specific Guidance

6.3.1 Notwithstanding SO6.1 these Standing Orders will be read in conjunction with all applicable law and guidance issued by the Secretary of State for Health and Social Care.

SO7 Duties and Obligations of Board Members under these Standing Orders

7.1 Declaration of Interests

7.1.1 The Code of Accountability requires Board Members to declare interests, annually or as and when they arise, which are relevant and material to the NHS board of which they are a member. All existing Board Members should declare such interests. Any Board Members appointed subsequently should do so on appointment. Anyone declaring an interest should refer to the Trust's Policy for *Standards of Business Conduct and Managing Conflicts of Interest.*

7.1.2 Interests, which should be regarded as "relevant and material", are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department.

g) Interests in pooled funds that are under separate management.

7.1.3 Any Board Member who becomes aware that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO7.1.2 or elsewhere) has any pecuniary interest, direct or indirect, the Board Member should declare his/her interest by giving notice in writing of such fact to the Board as soon as practicable.

7.2 Advice on Interests

7.2.1 If Board Members have any doubt about the relevance of an interest, this should be discussed with the Chair or Company Secretary or equivalent.

7.2.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The test of relevance is whether the interest might reasonably be thought by the public to affect the way in which an individual discharges his or her duties. The test therefore is not just whether an individual's actions will be influenced by the interest but whether the public might reasonably think this may be the case. The interests of partners in professional partnerships including general practitioners should also be considered.

7.3 Recording of Interests in Board minutes

7.3.1 At the time Board Members' interests are declared, they should be recorded in the Board minutes

7.3.2 Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.3.3 Board Members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.3.4 During the course of a Board meeting, if a conflict of interest is established, the Members concerned should declare such likely conflict of interest and withdraw from the meeting, unless requested to remain by the Board members present. The Member should play no part in the relevant discussion or decision.

7.4 Register of Interests

7.4.1 The Company Secretary or equivalent will ensure that a Register of Interests is established to record formally declarations of interests of Board. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in SO 7.1.2.

7.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.4.3 The Register will be available to the public and published in the Annual Report and on the Trust's website.

7.5 Exclusion of the Chair and/or Members from proceedings on Account of Pecuniary Interest

7.5.1 Definitions

7.5.1.1 'Person connected with a Member' shall include 'spouse' (as defined below) and any other person with whom the Member has a personal or professional relationship, including but not limited to a family member, friend or acquaintance.

7.5.1.2 'Spouse' shall include any person living in the same household and any pecuniary interest of a person living in the same household, if known to the Member, shall be deemed to be an interest of the Member.

7.5.1.3 'Contract' or 'Grant' shall include any proposal contract or grant or other course of dealing.

7.5.1.4 'Pecuniary interest'. Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter if:

- He, or a nominee of his, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.5.1.5 'Exception to pecuniary interests'. A person will not be regarded as having pecuniary interest in any contract or grant if:

a) neither they or any person connected with him has any beneficial interest in any securities of the company of which he or such person appears as a Member; and

b) any interest that he or any person connected with him may have in the contract or grant is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on that contract or matter; and

c) those securities of any company in which he (or any person connected with him) has a beneficial interest does not exceed £5,000 in nominal value or 1% of the total nominal value of the issued share capital of the company or body, whichever is the less. Provided that where this applies the person is nevertheless obliged to declare their interest in accordance with SO7.1.

7.5.2 Exclusion in proceedings of Board

7.5.2.1 Subject to the provisions of this Standing Order, if the Chair or a Member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.5.2.2 The Board may exclude the Chair or a Member of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

7.5.2.3 Any remuneration, compensation or allowances payable to the Chair or a Member by virtue of the NHS (consolidation) Act 2006 Schedule 3 Part 1 para 10. (shall not be treated as pecuniary interest for the purpose of this regulation.

7.5.2.4 This Standing Order applies to a Committee, sub-committee and joint committee as it applies to the Board and to any Member of such (whether or not he is also a Member of the Board).

7.5.2.5 The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him in the interests of the National Health Service that the disability shall be removed.

7.6 Standards of Business Conduct

7.6.1 Policy

7.6.1.1 All staff must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS Staff' and with the Trust's Code of Personal and Business Conduct provided in the Appendices to the Corporate Governance Manual.

7.6.1.2 It is an offence under the Bribery Act 2010 (previously the Prevention of Corruption Acts 1906 and 1916) for an employee of the Trust to accept corruptly any inducement or reward for doing, or refraining from doing, anything in their official capacity, or corruptly showing favour or disfavour in the handling of contracts. Breach of the provision of these Acts renders staff liable to prosecution and may also lead to the termination of their contracts of employment and superannuation rights within the NHS.

7.6.2 Interest of Officers in Contracts

7.6.2.1 If it comes to the knowledge of a Member or an officer of the Trust that the Trust has entered into or proposes to enter into a contract in which he or any person connected with him has any pecuniary interest he shall give notice of such fact in writing to the Chief

Executive or Company Secretary or equivalent as soon as practicable.

7.6.2.2 A member or officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.6.2.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.6.3 Canvassing of, and Recommendations by, Members in Relation to Appointments

7.6.3.1 Canvassing of Members of the Board or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.6.3.2 A Member of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment. This shall not preclude a Member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.6.3.4 Unsolicited informal discussions outside appointments panels or committees should be declared to the panel or committee.

7.6.4 Relatives of Members or Officers

7.6.4.1 Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to dismissal.

7.6.4.2 The Chair and every Member and officer of the Trust shall disclose to the Board any relationship with a candidate of whose candidature that Member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.6.4.3 On appointment, Members (and prior to acceptance of an appointment in the case of Executive Members) should disclose to the Trust whether they are related to any other Member or officer of the Trust.

7.6.4.4 Where the relationship of an officer or another Member to a Member of the Trust is disclosed SO7.5 shall apply.

SO8 Custody of Seal, Sealing of Documents and Signature of Documents

8.1 Custody of Seal

8.1.1 The Common Seal of the Trust shall be kept by the Company Secretary or equivalent in a secure place.

8.2 Sealing of Documents

8.2.1 The seal will not be affixed to any document without the prior authorisation of the Board, Board Committee or Executive Member duly authorised under the Scheme of Delegation.

8.2.2 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two persons duly authorised by the Chief Executive, and not from the originating department, and shall be attested by them.

8.2.2 The Executive Members and Company Secretary or equivalent are authorised by the Chief Executive to use the Seal of the Trust.

8.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 The Company Secretary or equivalent on behalf of the Chief Executive shall keep a register of sealings. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

8.3.2 A report of all sealings shall be made to the Board at least annually.

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, an Executive Member or the Company Secretary or equivalent, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive, Executive Members or Company Secretary or equivalent shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority, as per the Scheme of Reservation and Delegation.

8.4.3 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Reservation and Delegation but will not include the main or principal documents effecting the transfer (e.g., sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

SO9 Legal Proceedings

9.1 The Company Secretary or equivalent is authorised to accept service of all legal proceedings on behalf of the Trust. The address for the acceptance of all legal proceedings is:

Company Secretary
Corporate Management Office
Southport Hospital
Town Lane, Kew
Southport
PR8 6PN

9.2 The Company Secretary or equivalent is authorised to instruct solicitors to advise the Trust or defend the Trust from any legal proceedings or formal alternative dispute resolution in any case where such action is necessary to protect the Trust's interests, unless an Act of Parliament requires some other person to do so, or the Board gives express authority to another officer.

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB114/21**	**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 21/22 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
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

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

Activity Summary – May 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	May 2019	May 2020	April 2021	May 2021	Trend
Overall Trust A&E attendances	10,469	6,028	9,026	10,414	▲
SDGH A&E Attendances	4,918	3,590	4,938	5,338	▲
ODGH A&E Attendances	2,420	983	2,003	2,792	▲
SDGH Full Admissions Actual	1,090	1,084	1,297	1,380	▲
Stranded Patients AVG	191	123	160	149	▲
Super Stranded Patients AVG	79	41	47	41	
MOFD Avg Patients Per Day	67	38	47	44	▲
DTOC Unconfirmed Avg Per Day	8	-	-	-	
GP Referrals (*Exc. 2WW*)	2,756	795	1,668	1,722	▲
2 Week Wait Referrals	791	497	889	792	▲
Elective Admissions	200	45	123	159	▲
Elective Patients Avg. Per Day	6	1	4	5	▲

Activity Summary – May 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	May 2019	May 2020	April 2021	May 2021	Trend
Elective Cancellations	26	18	46	43	▲
Day case Admissions	1,843	488	1,247	1,215	▲
Day Case Patients Avg. Per Day	59	16	42	39	▲
Day Case Cancellations	45	9	50	68	▲
Total Cancellations (EL & Day Case)	71	28	96	111	▲
Total Cancellations (On or after day of admission, non clinical reasons)	7	0	3	6	▲
Outpatients Seen	22,701	12,453	19,909	19,670	▲
Outpatients Avg. Per Day	732	402	664	635	▲
Outpatients Cancellations	4,071	5,963	3,664	3,585	▼
Theatre Cases	598	204	420	455	▲
General & Acute Beds Avg. Per Day	No data	452	434	427	▼
Escalation Beds Avg. Per Day	19	0	0	0	
In Hospital Deaths	82	60	58	72	▲

Southport and Ormskirk Hospital NHS Trust

Trust Board - Integrated Performance Report

Head of Information Summary

The Trust Integrated Performance Report covers 4 areas aligned to Trust Strategic Objectives as follows:

Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

Operations - **S02** – *Deliver services that meet NHS Constitutional Standards and regulatory standards*

Finance - **S03** – *Efficiently and productively provide care within agreed financial limits.*

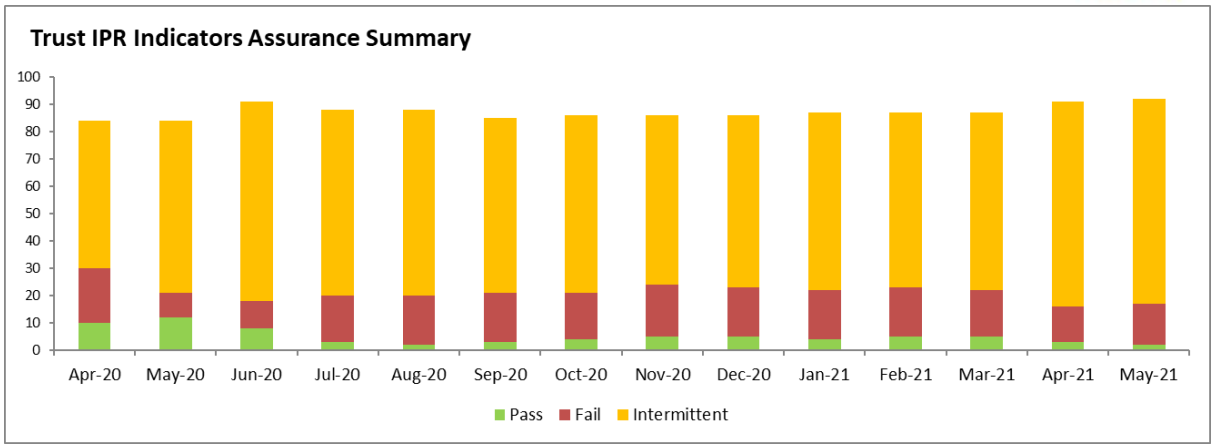
Workforce - **S04** – *Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated* and **S05** – *Enable all staff to be patient-centred leaders building an open and honest culture and the delivery of the Trust values.*

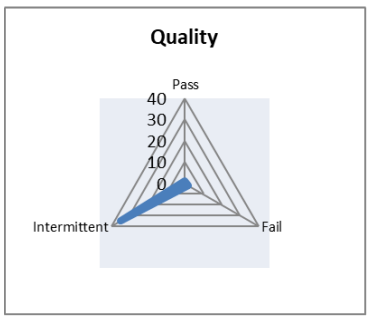
The majority of indicators in this month's IPR are still classed as intermittent. Only Care Hours Per Patient Day and Mandatory Training are classed as fully assured.

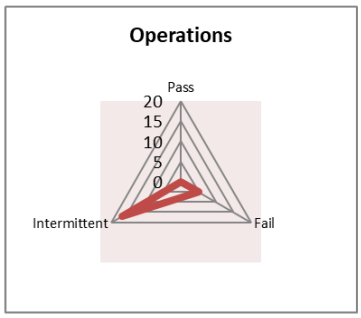
The following AAA will highlight any specific areas to the Board which they should be alerted, advised, or assured. These indicators have previously been presented to the Trust's three assurance committees.

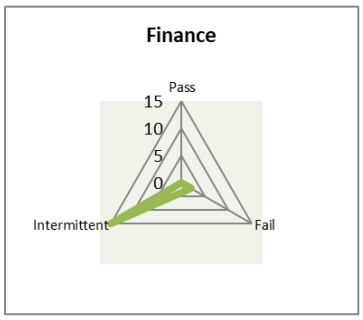
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Pass	10	12	8	3	2	3	4	5	5	4	5	5	3	2
Fail	20	9	10	17	18	18	17	19	18	18	18	17	13	15
Intermittent	54	63	73	68	68	64	65	62	63	65	64	65	75	75

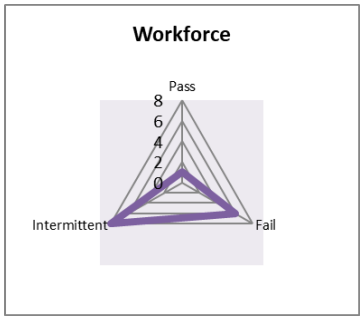
Southport and Ormskirk Hospital NHS Trust











ALERT

Quality: Metrics to be alerted to this month include the Neonatal Mortality Rate, at 5.5 per 1,000 births this is outside of the third control limit and is the second month in the last 3 where this has not been 0. The Trust SHMI is slightly improved this month and although is still classed as 'as expected' is much higher than 12 months ago. Finally, the Percentage of Deaths screened remains well below target and less than 20% for an eighth month in a row.

Finance & Operations: This month the committee are alerted to the number of 12 Hour trolley waits, 29 in May which is the most since December and January – narrative is outlined in the UEC paper provided to committee this month. The Total RTT Waiting List size has also increased to 11,106 which is a 7.2% increase on last month and a return to levels last seen in the months immediately before the first Covid-19 wave. Finally, in the Cancer section the Cancer 14 Day referral to Outpatients metrics is 87% in the latest reporting period (April 2021). Although not as low as in Autumn 2020 this is a drop from the previous month which was 90.6% against the 93% target.

Workforce: Indicators which the committee should be alerted to this month include the Sickness Rate (not related to Covid-19), which, although not failing in its assurance assessment has seen a further increase in May to 5.6% which is the highest for a number of months. In addition, Staff Turnover has seen a significant shift in month to 1.7% with the previous 6 months all below 1%. This appears to be driven by the Staff Turnover – Nursing element which itself has seen an increase in May to 2.4% from 0.7% the previous month.

Southport and Ormskirk Hospital NHS Trust

ADVISE

Quality: To advise the committee, Pseudomonas per 100,000 bed days and MSSA per 100,000 bed days in the IPC section have seen increases last month to 16.4 and 24.6 respectively from 0 the month before. In the Maternity section the % Women booked by 12 wks 6 days has dropped to 88.2% which is the lowest score since befoe April 2019. Finally in the Patient Experience section the Friends & Family Test - % Patients that would recommend is 89% in May, this is the 3rd consecutive decrease and remains well below the 94% target.

Finance & Operations: To advise the committee this month the number of 52 Week waits continues to reduce and is now down to 154, a 36% decrease from the previous month. More in depth analysis of RTT is provided in the Elective restoration paper provided to committee. The ED conversion rate at 21.7% is similar to last month and with volumes of attendances returning to pre-Covid baseline numbers this is likely to continue at the same level going forward. Finally, in the Finance section the Bank & Agency Run rate has decreased again to £2207K and continues a positive trend from a high of nearly £2800K in January 2021.

Workforce: This month's advisory notices include a much-improved position for Personal Development Reviews, up to 77.3% and the second successive increase. Medical Vacancy rate continues on an improving trajectory (down to 7.9%), as does the Nursing vacancy rate (10%) which are both significantly lower than 2019/20 values. Staff retention has seen a drop to 88.1% in May, this is outside of the lower control limit so is showing red on the SPC chart but is still assured overall and recent variation is positive.

ASSURE

Quality: For assurance, those metrics which are classed as assured in this month's IPR include CHPPD, which has been above target since February 2020. The HSMR at 79.3 continues an excellent trend and the 22nd month in a row below the national target of 100. Finally in the Patient Experience section both Duty of Candour indicators are 100%, and have been for an extended number of months.

Finance & Operations: There is only 1 metric which is fully assured, the Cancer 31 Day treatment (Surgery) measure. There are however other indicators which are showing a positive trend in recent months – notably ambulance handover times in ED and the length of stay for emergency admissions (excluding short stay) which at 8.5 days is the same as the peer target. Associated length of stay metrics Stranded, and Super Stranded patients are also showing a consistent and improved position from a 2019/20 baseline. In the Finance portfolio of metrics, the % Agency Staff (cost) continues a declining trend since Winter 2019/20 and also the last 3 months reported Cash Balance values are significantly lower than a high in February 2021.

Workforce: Metrics which can provide assurance to the Committee include the Mandatory Training rate, which at 86.8% remains above the 85% target. In addition, the Time to Recruit measure, latest performance is 51 days so has met the target of 55 days. This has been stable for a number of months with just natural variation seen on a month to month basis.

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Board Report

May 2021

Guide to Statistical Process Control

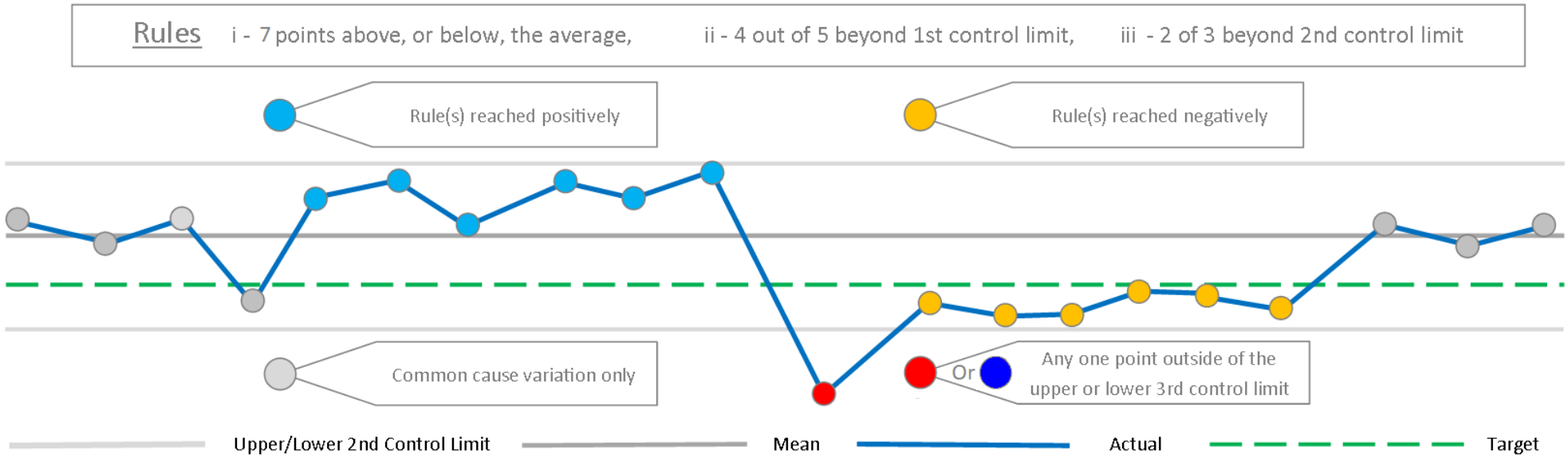
Southport and Ormskirk Hospital NHS Trust

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	4	0	0	1	6
	Mortality	1	0	3	1	1	0	0	2
	Patient Experience	1	0	7	0	1	3	1	3
Operations	Access	4	0	5	4	0	0	2	3
	Cancer	0	0	3	0	1	0	0	2
	Productivity	1	0	9	1	1	1	3	4
Finance	Finance	2	0	15	5	0	1	2	9
Workforce	Organisational Development	1	1	1	0	1	1	0	1
	Sickness, Vacancy and Turnover	5	0	7	6	0	0	3	3

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	WORKFORCE COMMITTEE
Meeting date:	29 JUNE 2021
Lead:	PAULINE GIBSON

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence
The sickness absence rate overall has remained static at 6% in month. The Committee were presented with a comprehensive presentation regarding sickness absence which detailed regional and CBU comparisons, long vs short term absence and the NHS England / Improvement Deep Dive. Assurance was received on effective management of sickness that was previously unqualified. A quarterly sickness absence presentation focussing on assurance from the activities undertaken will be delivered.

Staff Turnover
The staff turnover rate overall has increased from 1% in April 2021 to 1.7% in month, against a plan on of 0.75%. Turnover has increased in month as a direct result of leavers from paid placements. This remains an area of concern and ongoing monitoring.

ADVISE

PDRs
Compliance in PDRs have increased from 73.7% to 77.3% in month which is gradual but positive. This is the second successive increase in month of PDRs. Whilst this is short of the anticipated trajectory in some areas, there are clear plans in place to readdress the issues.

Medical Vacancies
The medical vacancy rate has dropped from 8.5% in April 2021 to 7.9%. There have been some great appointments made in month for hard to fill posts.

Nursing Vacancies
The nursing vacancy rate has increased from 9% in April 2021 to 10%. This rate is lower than the 2019/2020 values. The rates have increased as a direct correlation of 36 leavers from paid placements. However, International recruitment is making progress again after the pause due to the pandemic.

Bank and Agency staff costs
The percentage of Agency staff for cost has increased from 6.3% in April 2021 to 6.7% in month. This is expected to reduce over the coming months as there are early indications that overall demand is now falling for agency nursing, which will be further reinforced as the International and local recruitment activities result in appointments. There has been significant progress made in converting agency to bank.

Staff Retention
Whilst the Committee were assured by staff retention rates decreasing from 89.1% in April 2021 to 88.1% in month, it was recognised that improvements are still required. A proactive approach is being taken for flexible working for potential retirees.

Undergraduate Deans Visit – July 2021
Evidence was provided to the Committee of the work undertaken to address the actions identified from the previous Dean's Visit in 2020. Not all actions have been completed or embedded which leaves a residual risk. There is an ongoing plan to address this.

ASSURE

Mandatory Training
Mandatory Training compliance has increased in month to 86.5% which is above the 85% target; an occurrence that is consistently delivered. There are plans in place to exceed the current target and the Committee were strongly assured.

Time to Hire
The time to hire has decreased 48.8 days in month, which has hit the target. This is a stable and improving performance with good progress demonstrated towards the stretch target of 30 days.

IPR
The Chair recognised the early indicators of improving trends and commended the Workforce Directorate, CBU Leads and Staff Side for the strong partnership working which is sitting behind this positive movement.

Communications and Engagement Strategy
The strategy was approved.

New Risk identified at the meeting	None.

Review of the Risk Register
(Detail the risks on the Committee's risk register that were reviewed in the meeting, including scores C&L and current actions)

Workforce

Sickness, Vacancy and Turnover

Analyst Narrative:

Several indicators within this section are failing assurance in relation to sickness, vacancies and turnover. The rolling 12 month sickness rate is showing recent special cause concern although has been reducing since March. Nurse sickness is showing special cause concern with a further incremental increase in May. Whilst all vacancy rate indicators are failing their assurance measure, both medical and nursing vacancy rates are showing recent special cause improvement. Rolling staff turnover continues to fail its assurance measure and is also showing special cause concern with an increase in May, impacted by a significant increase in the in-month turnover.

Operational Narrative:

Rolling 12 month sickness - the recovery and reset phase has focussed since March in gaining assurance and taking action where necessary to ensure that long term sickness cases are being actively managed and that colleagues who are absent have been appropriately supported. Assurance is there that this is the case with many cases now closed. Short term absence is on the rise in terms of number of absences, so work is now underway to establish what levels of management intervention have taken place since the lifting of the SPF pause earlier in the year. The majority of action in these cases sits with operational managers so work is underway to provide evidence of assurance that that activity has been appropriately undertaken.

Nurse sickness – 52 separate absences open in any part of May with only 8 remaining open at the end of the month. The remaining 44 were all closed during May with 43 of these opening and closing in May itself. Of the 8 open ended absences at the end of May, all commenced in April or May with there being a 50/50 split LTS to STS.

Increase in non-covid sickness although overall sickness has remained consistent – there are daily fluctuations in the numbers but the numbers are relatively static and short term in nature.

Trust vacancy rate - whilst we are not yet reaching our target to reduce vacancies it is clear that significant progress is continuing to be made, and the current international recruitment activity and pipeline of medical recruits will have a positive impact on this. The pause in international recruitment and difficulty in relocating to the UK for some overseas recruits has caused some delays, however the pause has now been lifted and we are working on a plan with our colleagues in the pan Mersey collaborative to quickly improve this position. We have also managed to recruit to all healthcare assistant vacancies, which will provide a significant level of support and stability to the wards.

Both medical and nursing vacancies rates are showing improvement and we have further international nurses due to arrive very early in July, following the lifting of the pause in recruitment from India. We have 31 international nurses who are currently in the HCA numbers, but have now completed their OSCE and will receive their NMC Pin number shortly, this moving them into the nursing numbers, which will provide a further significant improvement.

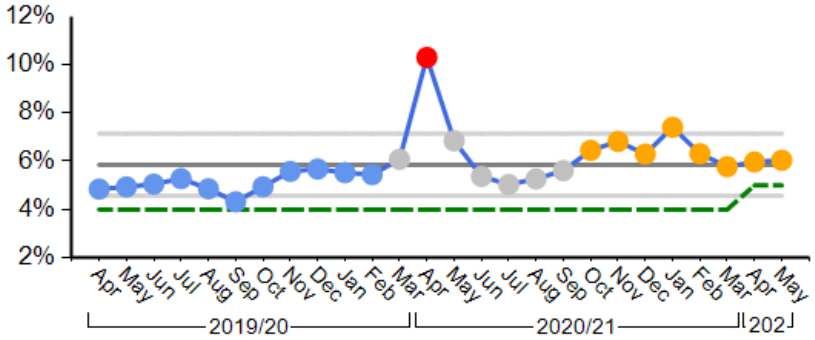
We have 13 medical vacancies currently under offer with notable success with an offer made for a consultant in Diabetes. We have also received an increased number of applicants following our engagement with an increased number of permanent recruitment agencies. As we are now tackling the most difficult of the vacancies it is increasingly important that the Recruitment team and CBUs work closely to provide a quick response to CVs and move to interview swiftly. To support this weekly meetings have been set up to allow regular review and ensure that blockers are dealt with quickly.

Time to Recruit is progressing well; however we are continuing to monitor and carry out a full review each month as we work towards our stretch target. The significant amount of international recruitment does cause some additional delays in time to hire, but we are working with the CBU’s and relevant external agencies to remove as many barriers as is possible.

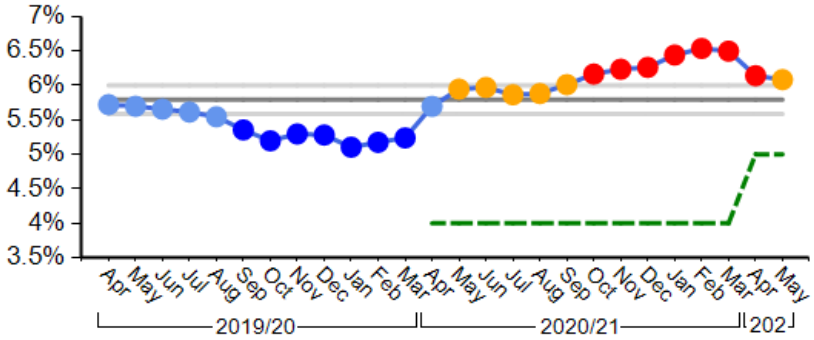
Rolling staff turnover is still impacted by the students carrying out paid placements, which were completed in August last year, and a further spike has been generated by the completion of the second tranche of paid placements which were completed in May 2021.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	5%	6%	N/A	May 21		5%	6%	Apr 21	5%	6%	
Sickness Rate (Rolling 12 Month)	5%	6.1%	N/A	May 21		5%	6.1%	Apr 21	5%	6.1%	
Sickness Rate - Medical Staff	5%	1.7%	N/A	May 21		5%	2.4%	Apr 21	5%	2%	
Sickness Rate - Nursing Staff	5%	8.1%	N/A	May 21		5%	7.9%	Apr 21	5%	8%	
Sickness Rate (not related to Covid 19) - Trust		5.6%	N/A	May 21			5.4%	Apr 21		5.5%	
Trust Vacancy Rate – All Staff	6.8%	9.2%	N/A	May 21		6.8%	8.6%	Apr 21	6.8%	8.9%	
Vacancy Rate - Medical	7.4%	7.9%	N/A	May 21		7.4%	8.5%	Apr 21	7.4%		
Vacancy Rate - Nursing	9%	10%	N/A	May 21		9%	9%	Apr 21	9%		
Staff Turnover	0.75%	1.7%	N/A	May 21		0.8%	1%	Apr 21	9%	6.8%	
Staff Turnover (Rolling)	10%	14.5%	N/A	May 21		10%	13.8%	Apr 21			
Staff Turnover - Nursing	0.8%	2.4%	N/A	May 21		0.8%	0.7%	Apr 21	9.6%	1.6%	
Time to Recruit	55	51	N/A	May 21		55	58	Apr 21	55	55	

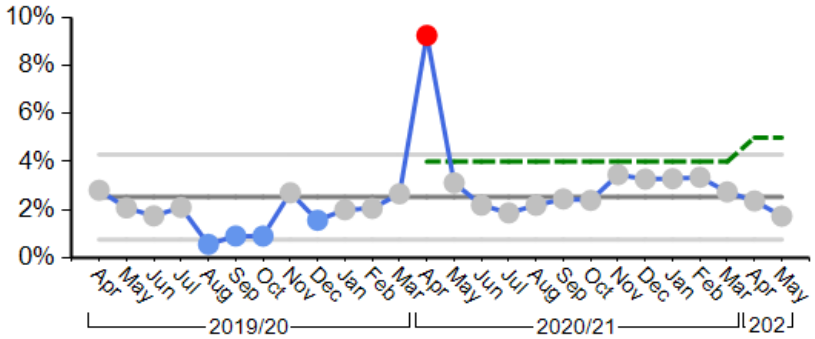
Sickness Rate



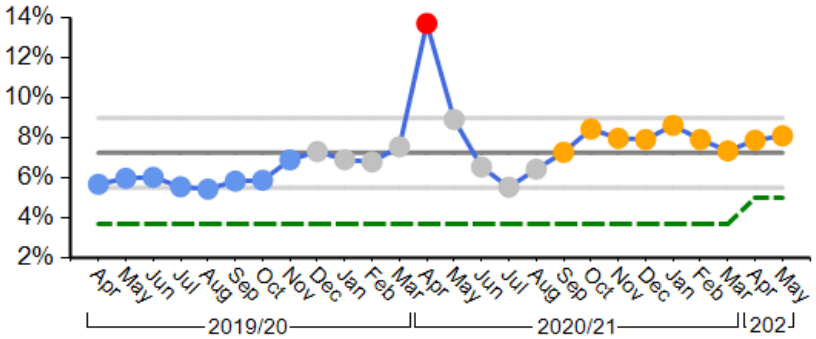
Sickness Rate (Rolling 12 Month)



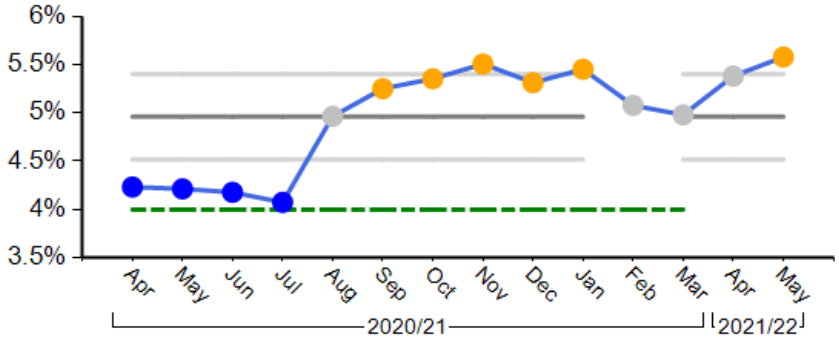
Sickness Rate - Medical Staff



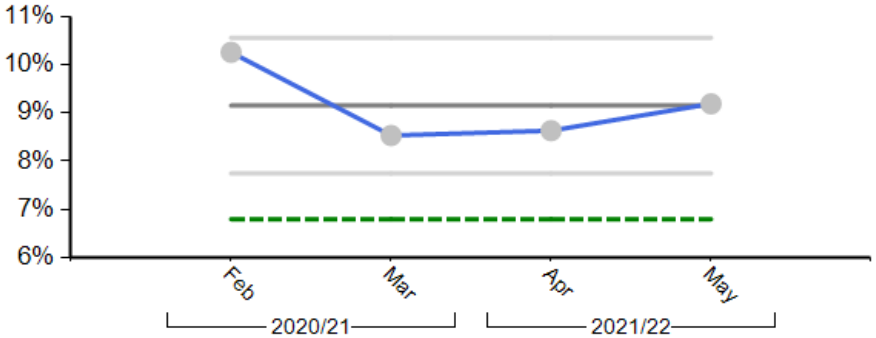
Sickness Rate - Nursing Staff



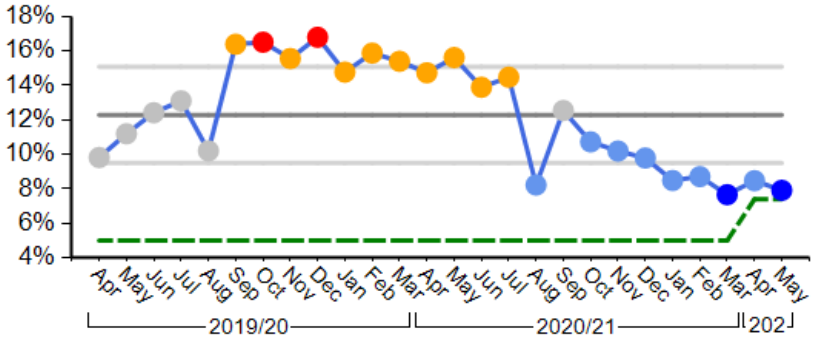
Sickness Rate (not related to Covid 19) - Trust



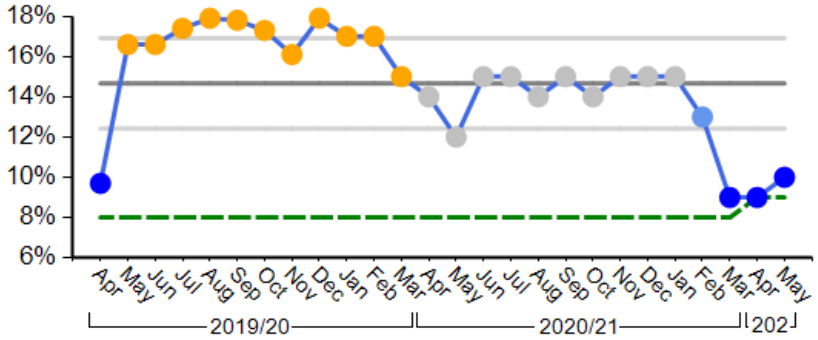
Trust Vacancy Rate – All Staff



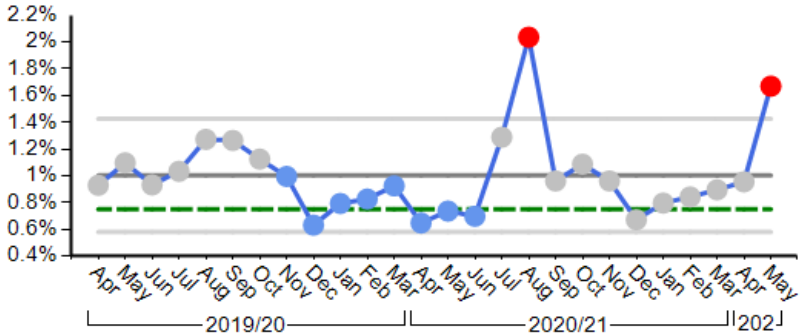
Vacancy Rate - Medical



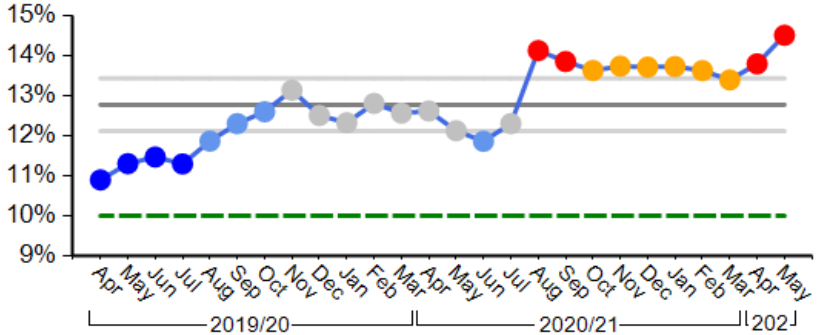
Vacancy Rate - Nursing



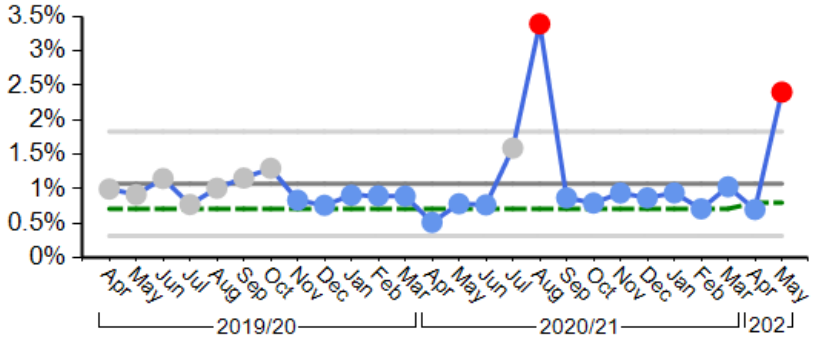
Staff Turnover



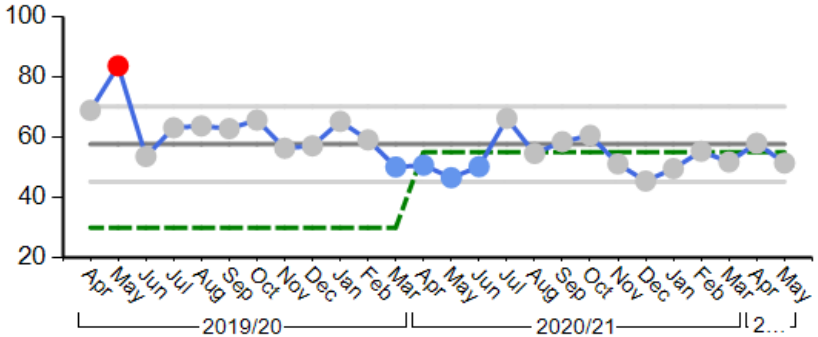
Staff Turnover (Rolling)



Staff Turnover - Nursing



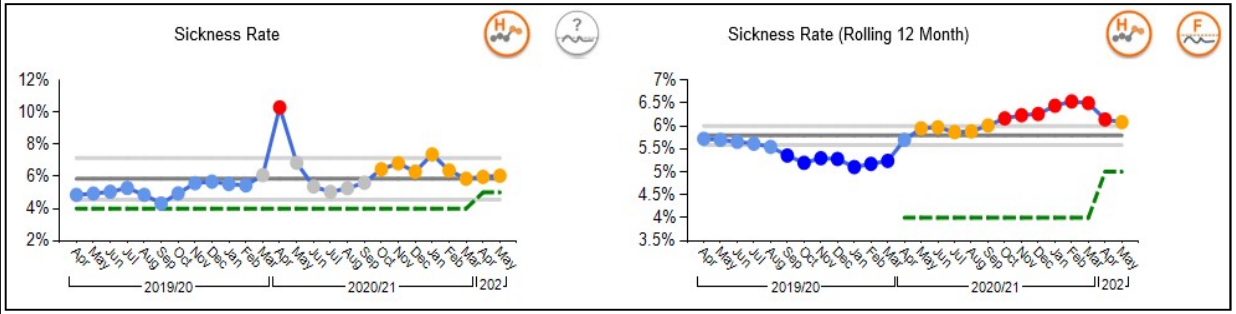
Time to Recruit



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	May 21	H	5%	6%	Apr 21	5%	6%	?
Sickness Rate (Rolling 12 Month)	5%	6.1%	N/A	May 21	H	5%	6.1%	Apr 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:

LTS sickness rising compared with short term.

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'
- Assurance that LTS cases are being actively managed. This month focus on short term persistent absence.

Mitigations:

MIAA Audit undertaken October 2020

NHSE&I deep dive to commence late June 2021

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB115/21**	**FOI Exempt**	**YES**
Report Title	**OUR PEOPLE PLAN – PROGRESS UPDATE**		
Executive Lead	Jane Royds, Director of HR & OD		
Lead Officer	Sonya Clarkson, Deputy Director of HR & OD		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

This report provides the bi-monthly update on the progress against the key programmes of work identified in the Trust's 'Our People Plan'.

Executive Summary

Work is well underway to support delivery of the Trust's Our People Plan with steady build-up of momentum to secure sustainable, transformational changes for the workforce over the coming two to three years.

Robust governance arrangements are in place to ensure ownership and engagement across the organisation, and to monitor the delivery of the key programmes of work identified. Furthermore, horizontal alignment is strengthening across other significant strategic plans, such as Shaping Care Together, Fragile Services and the Digital Strategy, increasing potential for transformational impact.

Staff engagement at all levels of the Trust is also evident with a growing OD network of new roles, such as 12 Cultural Ambassadors, 80 Ambassadors for Hope, 12 Wellbeing Guardians and 11 Champions to support delivery of Our People Plan. Three staff network meetings have also taken place, with next steps to invite staff from under-represented groups to review the EDI policy, Work/life balance policy, the Recruitment and Selection process and positively impact on equality outcomes (i.e. WRES disparity ratio).

The Valuing Our People Inclusion group will act as a forum for staff to share lived experiences of the Trust, and from the 01 July 2021, the Trust will routinely ask staff for feedback through the quarterly staff survey. Both will support the regular review of our people-related activities to ensure improvements are being made. From September 2021, the Workforce Committee will receive a quarterly dashboard showing the progress being made against Our Measures of Success.

Recommendation

The Board is asked to note the progress being made to provide assurance on delivery of the Trust's Our People Plan.

Previously Considered By:

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

Strategic Objectives

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

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

Our People Plan – Progress Update

1. Purpose

This report provides the bi-monthly update on the progress against the key programmes of work identified in the Trust's *Our People Plan*.

2. Key deliverables 2021/22

Against the key deliverables identified in Our People Plan, the majority are now underway as outlined in Appendix 1.

3. Valuing Our People Inclusion Group

Valuing Our People Inclusion Group (VOPIG) is now fully established and is responsible for overseeing the progress against two key themes in Out People Plan: *Looking after Our People and Belonging to the NHS*.

The 2021/22 key programmes of work have been informed by feedback from the 2020 Annual Staff Survey. As VOPIG evolves, it will act as a forum for staff to share their lived experiences and shape priorities for action, ultimately promoting a supportive and inclusive culture of openness, honesty and learning. On 01 July 2021, the quarterly staff survey will be launched, providing further opportunity to continuously review our people priorities.

Appendix 1 shows the programme of work for 2021/22 and progress to date. The impact of this activity will be evaluated against the measures identified (ref section 7).

Key highlights since the last progress report:

- Alignment of SCOPE values to all the Our People Plan work programmes.
- 3 Staff Network meetings have taken place and members will be asked to help review EDI policy, Work/life balance policy, the Recruitment and Selection process and positively impact on equality outcomes (i.e. WRES disparity ratio).
- Increased cultural awareness in staff communications, such as Eid festival.
- Growing OD network to support delivery of Our People Plan, with new roles such as 12 Cultural Ambassadors, 80 Ambassadors for Hope, 12 Wellbeing Guardians and 11 Champions.
- Roll out REACT mental health training to guide managers to hold conversations and inform next steps in this context.
- Secured 6 places to Schwartz Rounds facilitators on the regionally funded programme

4. Workforce Improvement Group

The reinstated Workforce Improvement Group has now finalised its Terms of Reference and will oversee the Our People Plan thematic area *New Ways of Working and Delivering Care.* Activity has been organised under four key work programmes:

- Agile working
- Workforce systems development
- Clinical workforce plan including joint appointments with partner organisations
- Change management

Whilst activity is very much in the development stages, the value of group in ensuring horizontal alignment with other Trust-wide programmes and strategies (such as Shaping Care

Together, Fragile Services and Digital) is already becoming clear, increasing the potential for transformational impact of the group's activity.

Improvement outcomes have been identified for each work programme, although the 'workforce systems development' programme is a good example of the link to Use of Resources Group and the potential for financial impact.

Recognising how the current low PDR compliance rates undermines a key aspect of the group's work (i.e. the role of PDRs in managing change effectively and preparing staff for the direction of travel for the Trust), the group will act as a further mechanism for driving up compliance rates.

5. Our Resourcing Plan

A refreshed resourcing strategy is currently under consultation defining the Trust's approach to *Growing for the Future.* The plan will recognise the deliverables identified for 2021 are remedial actions to help address the current staffing shortages, and the need to explore new talent pipelines as a more sustainable, long term solution.

6. Staff communication and engagement plan

The Trust's Communication and Engagement Plan (due to be approved by the Workforce Committee) is aligned to Our People Plan. The aim of the engagement approach is to help staff build up awareness of Our People Plan and understand their part in realising the benefits within it. Broad indications of the levels of awareness will be:

Level 1 Staff are aware of the Trust's SCOPE values, able to talk about them and speak up when they are not experiencing them.

Level 2 Staff are aware of 2 out of 4 themes within Our People Plan and are talking about them.

Level 3 Staff are aware of 4 out of 4 themes within Our People Plan and are talking about them.

Level 4 Staff engage in activities knowing it contributes to Our People Plan, by sharing stories, initiating action and working together.

The launch of the quarterly staff survey on 1st July will signal the start of staff engagement with Our People Plan.

7. Our measures of success

Appendix 2 shows the aspirational targets and impact Our People Plan intends to make by 2022/33. A dashboard is under development to enable monitoring by the Workforce Committee on a quarterly basis (in line with the quarterly staff survey results) and aiming to go live in September/October 2021 (dependent on when data available from quarterly staff survey).

8. Recommendations

Workforce Committee to note the progress being made to provide assurance on delivery of the Trust's Our People Plan and agree to receive a quarterly update report going forward.

Appendix 1 Our People Plan – Key Deliverables 2021/22

Key Areas of Focus	Key deliverables 2021/22	Progress Update
Looking after our people	Enhanced wellbeing support to support recovery and reset	On track
	Revise and align staff engagement strategy	On track
	Re-establish Valuing Our People (Inclusion) Group	Completed
	Deliver on our Staff Engagement Action Plan	In progress
	Align Trust values to staff recognition strategy	In progress
	Implement Schwartz Rounds and continue with 'Back to Floor'	On track
	Develop an annual HR Policy Development framework and embed Just and Learning principles	In progress
	Develop bitesize sessions for managers for induction and appraisal	In progress
Belonging to the NHS	Launch the first Trust Diversity calendar of events	In progress
	Incorporate Anti-Racism / Active Bystander training	In progress
	Establish Staff Networks	In progress
	Revise and align leadership development strategy and develop succession planning framework	In progress
	Introduce reverse mentoring	In progress
New ways of working	Increase opportunities for flexible working	In progress
	Develop HR systems roadmap	In progress
	Develop Trust Clinical Workforce Plan	In progress
	Deliver PDR Improvement Plan	In progress
Growing for the future	Revise and align Recruitment Plan, and deliver on nurse recruitment (150 IR nurses)	In progress
	Increased placements offered to medical, nursing and AHP students with Edge Hill and UCLAN	In progress
	Extend collaborative bank to Allied Health Professionals	Not started

Appendix 2 Our measures of success

Looking after our people

- Staff Survey – Improvements each year in staff engagement score measured by the national staff survey (stands at 6.74 in 2019 and 6.86 in 2020)
- Quarterly Pulse Survey – improvements each quarter measured by national quarterly survey
- Health & Wellbeing – improvements each year in national staff survey question ' The Trust takes an interest in and action on health and wellbeing'
- Reduction in formal employee relations cases
- Sickness absence rates (non-covid related) <5% by 2022 and reduction in long term absence (stands at 57% of absences in 2020)

Belonging to the NHS

- Staff Survey – improvements each quarter and year in national staff survey and pulse survey questions 'Recommend as place to work and provide treatment and care'
- Equality Diversity Inclusion – WRES and WDES outcome improvements, measured each year
- Improvements each year in national staff survey questions on 'support from immediate managers' and 'recognition and value of staff by managers and the Trust'
- Increased number of staff networks established at the Trust

New ways of working and delivering care

- Flexible working – improvements each year in national staff survey question on 'being satisfied with flexible working opportunities' – to be above sector average
- Remain above mandatory training compliance target of 85% (stretch target 90%)
- Appraisal completion minimum 85% (stands at 69.1% for 2019/20)
- Fragile Services metrics i.e. % vacant, length of time vacant

Growing for the future

- Meet annual Public Sector target for apprenticeships (2.3% of workforce registered)
- Achieve a vacancy rate of 9% or less for nursing and 7.4% or less for medical
- Achieve annual agency spend target set by NHS Improvement each year
- Bank growth each year of 5% and nursing bank fill of at least 90%
- Improved non medical time to hire to 30 days and medical time to hire <50 days

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	28 JUNE 2021
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Committee received the month 2 financial report, which illustrates risks to achieving a balanced budget in h1 2021-22. A breakeven plan relies upon securing £0.8m Elective Restoration Fund in the first half of the financial year, and generating CIP savings of £3.7m, and there are risks to achieving both. Potential for remedial action is being identified to provide mitigation.

ADVISE

- It was reported that the Trust is performing ahead of plan in reducing the number of 52-week breaches. There were 153 cases at the time of the committee, which illustrates a sharp decline since March 2021, and 50% of those cases have a TCI in place for treatment.
- The Committee were advised of the surge in demand for urgent care, with record attendances in ED during May. This is putting substantial pressures upon the service that is impacting 4 hour and 12-hour performance targets, although corridor care still remains at zero. The committee were pleased to hear the impact that the 'Perfect Week' initiative has had upon relieving bed occupancy in response to service pressures, with a view that the good practice demonstrated should continue where possible.
- The Committee received a detailed update on fragile services and were advised that a full-service review is to take place across the Trust to identify any emerging changes and co-dependencies to service fragility. The committee were advised that the full-service review will not delay the progress underway to support previously identified 'red' services.
- It was reported that the Total RTT waiting list size has increased to 11,106 which is a 7.2% increase on last month and a return to levels last seen in the months immediately before the first Covid-19 wave. Alongside this information, the Committee was provided with a detailed update regarding the Trust's approach to risk stratification and clinical harm review.
- The Committee agreed that, to support the IPR summary, operational reports from PIDA meetings will feed in to the IPR presentation at future FP&I meetings, to provide operational context to the statistical assessment of performance and risk.
- The Committee received a final version of the Trust's IT strategy 2021-2024. Whilst the quality of the strategy was acknowledged, the Committee has requested the detailed workplan that will provide assurance and credibility of the deliverability of the strategy road map.
- It was reported to FP&I through the Estates & Facilities Committee that it is now a statutory requirement for the Trust to complete the patient safety elements of the Premises Assurance Model (PAM) and submit this to NHSEI.

ASSURE

- The committee received proposals to award the Fire Alarm System contract to the value of £1.378m to Trinity Fire & Security Systems Ltd and agreed a recommendation to the Board to approve the contract award.
- The Committee received proposals to award Johnson & Johnson Medical Ltd a four-year contract worth £224k to provide trauma products to the Trust, and the committee recommend approval by the Board of this submission. This will commence in July and will save the Trust £12k in 2021/22 and £15k in 2022/23

New Risks identified at the meeting: None

Review of the Risk Register: *No action taken*

Operations

Access

Analyst Narrative:

Four indicators are currently failing their assurance measure; Accident & Emergency - 4 Hour compliance, Ambulance Handover 30-60 Mins, Diagnostic waits and Referral to treatment: on-going. The A&E 4 hour standard has declined in month, although it remains within expected levels, alongside this, the 12+ hour trolley waits is now showing special cause concern with 29 reported in May. Despite Ambulance Handover 30-60 Mins failing its assurance measure, recent performance on both Ambulance metrics are showing recent special cause improvement. The Total RTT Waiting List is showing special cause concern this month due to a significant increase, and although the 42 and 52 week metrics continue to show special cause concern, both have improved in the last month.

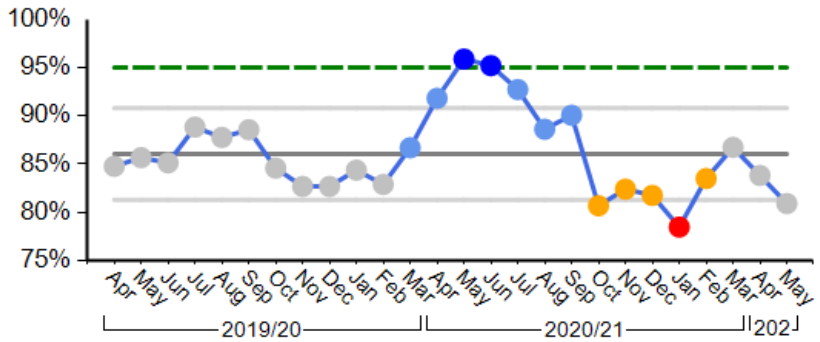
Operational Narrative:

A&E 4 hour compliance - 80.9% for the month of May 2021. Quarter 1 compliance is 82.28% to date. The month of May witnessed exceptionally high attendances at both SDGH and ODGH with record number of patients presenting and an increase of Majors attendances across both sites. Unfortunately, in month there were 29 breaches of 12 hour trolley wait standard, of which 8 were related to mental health attendance and the remaining 21 were patients awaiting admission to acute beds on SDGH site. Year to date 12 hour breaches stands at 37. The Trust set a target of 85% compliance against the four hour standard by 30.6.21. The department at SDGH continues to suffer breaches of the 4 hour standard due to delays with admission swabs and challenges into the evening and overnight due to limited senior decision makers. The Urgent and Emergency Care Improvement Group is established and attended by community and commissioning colleagues. A key work stream internally includes the review of Tier 1 to Tier 3 staffing for ED on both sites, the Nursing establishment review for ED is complete and Statement of Case is in development. Attendances to Paediatric A&E still remain high with attendances jumping from 2,004 in April to 2,794 in May – a 39% increase. Despite this 4 Hour performance still remains above the 95% target at 98.8%.
Ambulance handovers - There was a small deterioration in performance against the 30 minute standard in month attributable to high occupancy levels in the ED and delays for admission to mental health and acute beds.

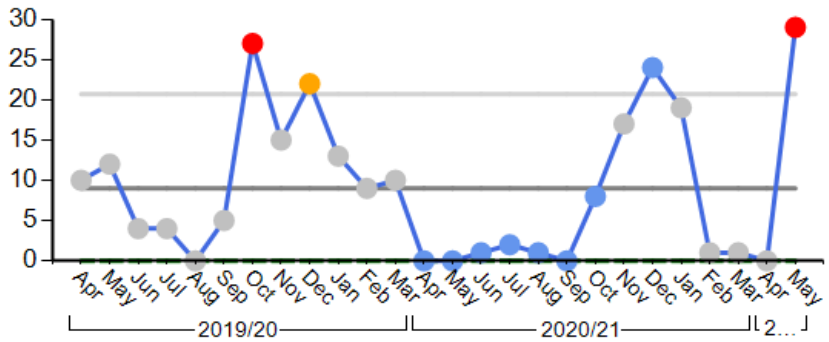
Please also refer to supporting action plans for RTT and Diagnostics.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	80.9%	1987	May 21		95%	83.8%	Apr 21	95%	82.3%	F
Accident & Emergency - 12+ Hour trolley waits	0	29	29	May 21	H	0	0	Apr 21	0	29	?
Ambulance Handover 30-60 Mins	0	55	55	May 21	L	0	30	Apr 21	0	85	F
Ambulance Handover Over 60 Mins	0	4	4	May 21	L	0	8	Apr 21	0	12	?
Diagnostic waits	1%	17.6%	726	May 21		1%	15.5%	Apr 21	1%	16.5%	F
Referral to treatment: on-going	92%	83.7%	1807	May 21		92%	82.1%	Apr 21	92%	83%	F
Total RTT Waiting List - Trust		11106	11106	May 21	H		10352	Apr 21		11106	?
52 Week Waits	0	154	154	May 21	H	0	242	Apr 21	0	242	?
Total 52 week waits – completed		105	N/A	May 21	H		122	Apr 21		227	?

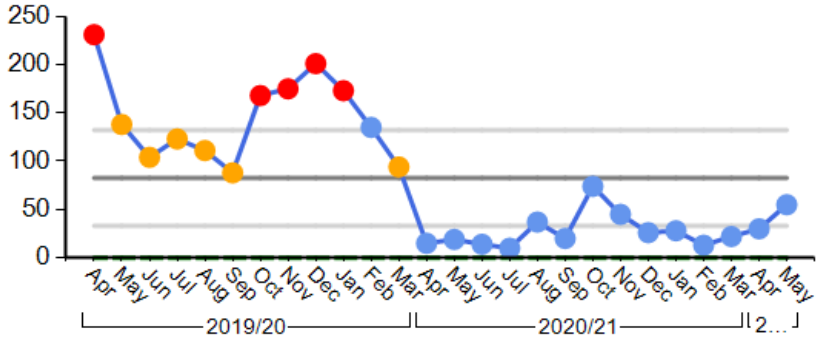
Accident & Emergency - 4 Hour compliance



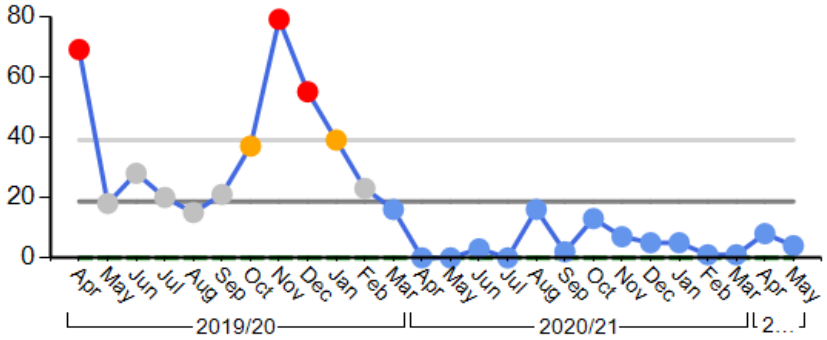
Accident & Emergency - 12+ Hour trolley waits



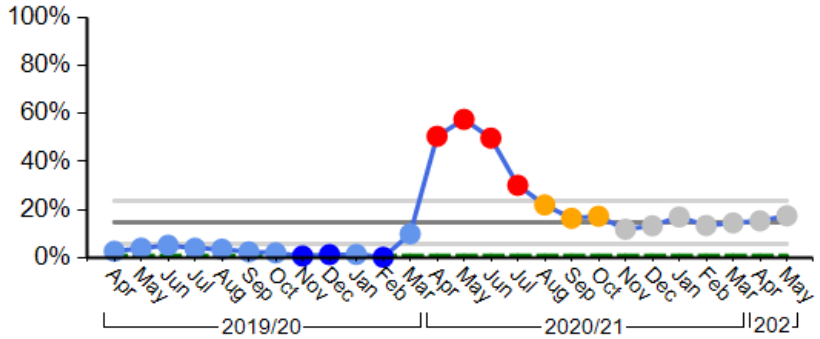
Ambulance Handover 30-60 Mins



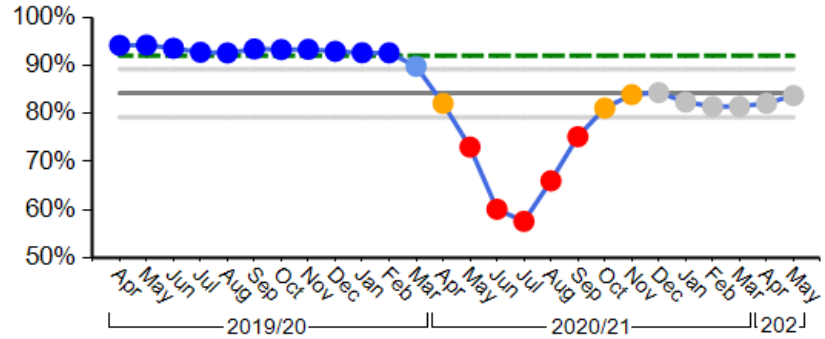
Ambulance Handover Over 60 Mins



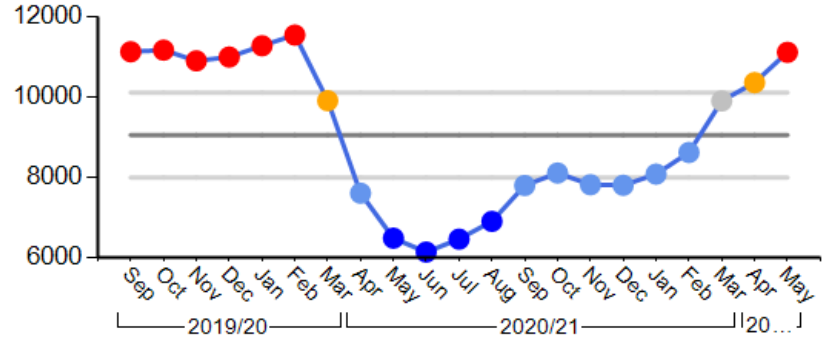
Diagnostic waits



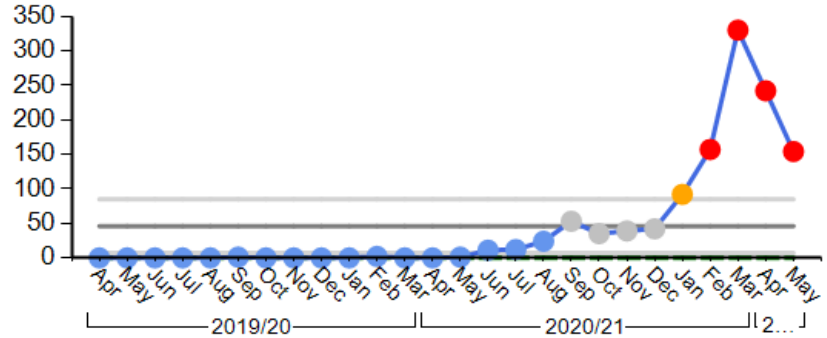
Referral to treatment: on-going



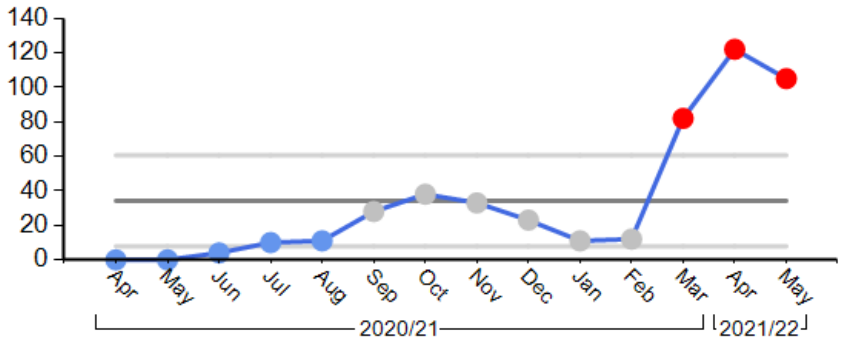
Total RTT Waiting List - Trust



52 Week Waits



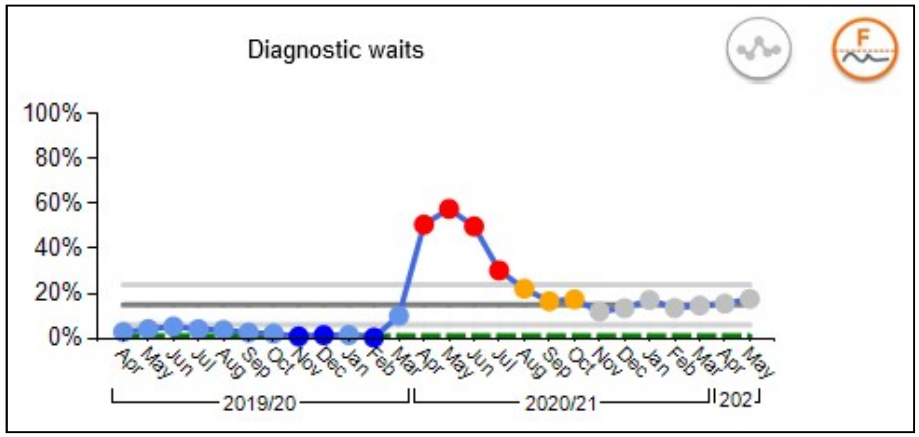
Total 52 week waits – completed



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%	17.6%	726	May 21		1%	15.5%	Apr 21	1%	16.5%	F



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 and Radiographer workforce with continued difficulties being able to recruit.

Workforce constraints within some diagnostic procedures including some single point of failures.

Increase in sickness in Nurse Endoscopy workforce.

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 approved via WLI's and insourcing, this will be ongoing to improve recovery position and reduce wait times. Currently awaiting costs to outsource Nurse Endoscopy through Your World.

Additional CT capacity sought from St Helen's and Knowsley Trust.

Recruitment to Radiology Consultant and Radiographer posts.

FIT testing for surveillance patients - patients have been Identified, funding signed off, awaiting Cancer Alliance Funding Manager to provide promised project management support to commence.

Estates work in Endoscopy escalated to Risk Register and costings are being obtained.

Mitigations:

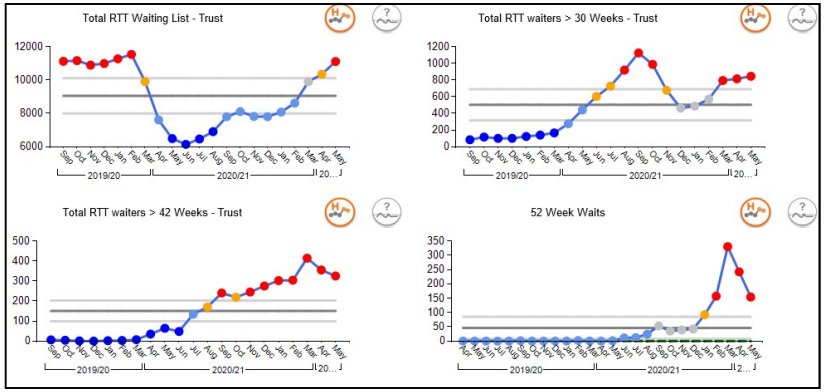
Recovery plans are in place.

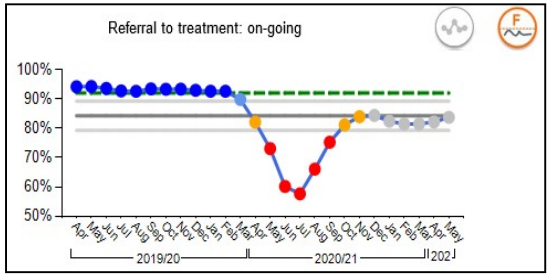
Ongoing validation of DM01 patient tracking list

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%	83.7%	1807	May 21		92%	82.1%	Apr 21	92%	83%	F
Total RTT Waiting List - Trust		11106	11106	May 21	H		10352	Apr 21		11106	?
Total RTT waiters > 30 Weeks - Trust		845	845	May 21	H		814	Apr 21		845	?
Total RTT waiters > 42 Weeks - Trust		325	325	May 21	H		355	Apr 21		325	?
52 Week Waits	0	154	154	May 21	H	0	242	Apr 21	0	242	?





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. Performance in May is showing improvement.

Issues:

Several specialities are currently failing. Gynae, Vascular, General Surgery, Gastro and Trauma & Orthopaedics are the worst affected.

T&O and General Surgery are impacted by theatre lists taken over by trauma and cancer. There are workforce issues within Vascular caused by insufficient Clinicians from LIVES contract, and nursing issues.

Referrals into the Trust continue on an upward trend.

The ongoing issues of estate and sickness remain.

Bed occupancy at SDGH remains high resulting in some cancellations.

Ongoing requirements for patients to undertake Covid tests and self-isolate.

Actions:

Focus on dating all P2 specialities—all P2 patients to be dated, as a minimum, if not treated within 28 days, currently patients are being booked and the P2 position is expected to improve.

Gynae has pre-Covid theatres back to capacity. Managing theatre capacity depending on individual specialities situations and workforce constraints.

Undertaking process to re-categorise some patients.

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.

Looking to provide extra weekend sessions —Ophthalmology, Urology and T&O.

The Trust now has a sub-contract with Renacres to deliver activity as part of the Trust recovery plan.

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. Ongoing validation of lists to ensure duplications are removed.

Use of virtual appointments where possible

Second best performer in C&M at dating P2.

Operations

Cancer

Analyst Narrative:

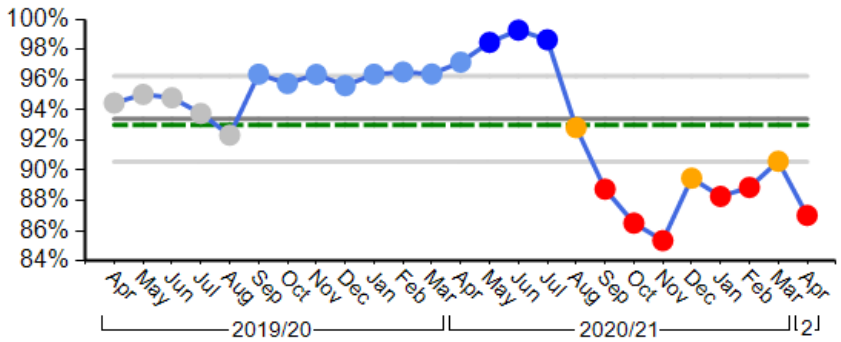
The 14 day GP referral to Outpatients continues to show special cause concern with a further decline in performance in April. This remains a cause for concern. The 31 day treatment was again ahead of plan in April; this performance needs to be sustained to be assured. Performance on the 62 day GP referral indicator has marginally increased in April but it remains below plan. This requires further narrative.

Operational Narrative:

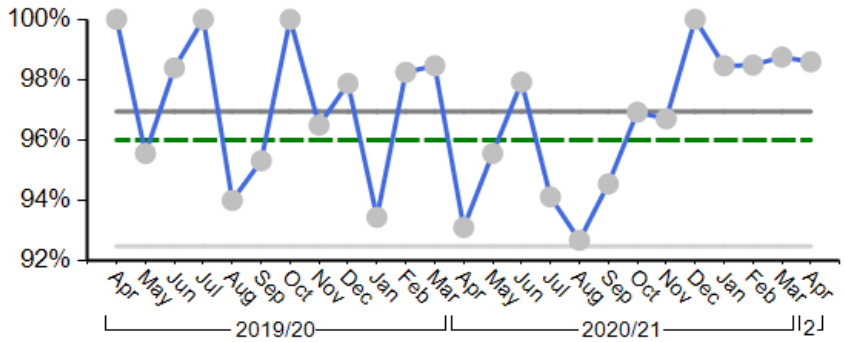
In addition to ongoing concerns with waiting times for endoscopy which affects our straight to test 14-day patients, gynaecology capacity is insufficient for rapid access clinic slots. Additional lists are being put on where possible to meet demand in endoscopy with all but colonoscopy waits now below 14 days (colonoscopy is at 17 days). A new Gynaecology consultant is due to start to address the rapid access backlog and waits. Theatre capacity continues to be carefully managed to enable the 31-day standard to remain compliant. Breaching the 14-day target has an unfortunate effect on the 62-day target too, resulting in longer waits in the patients' diagnostic phase. An analysis of breach reasons for the 62-day standard in April found 13 due to diagnostic delays, 5 patient illnesses or co-morbidity, 1 patient and 1 tertiary delay. The number of patients treated on time remained high with 39.5 treated within 62 days of referrals.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	87%	125	Apr 21		93%	90.6%	Mar 21	93%	87%	
31 day treatment	96%	98.6%	1	Apr 21		96%	98.8%	Mar 21	96%	98.6%	
62 day GP referral to treatment	85%	71.8%	15.5	Apr 21		85%	70.9%	Mar 21	85%	71.8%	

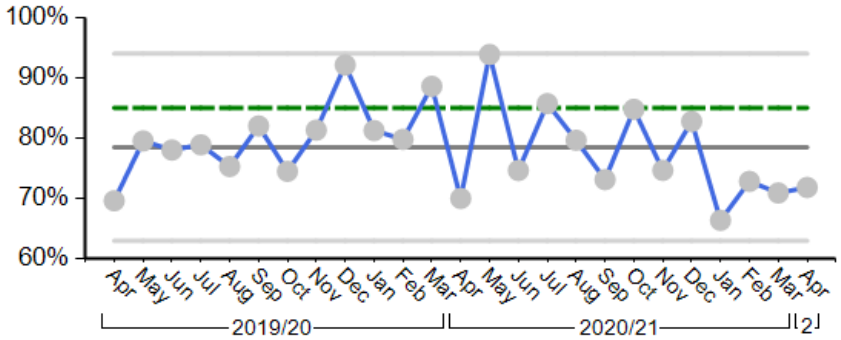
14 day GP referral to Outpatients



31 day treatment



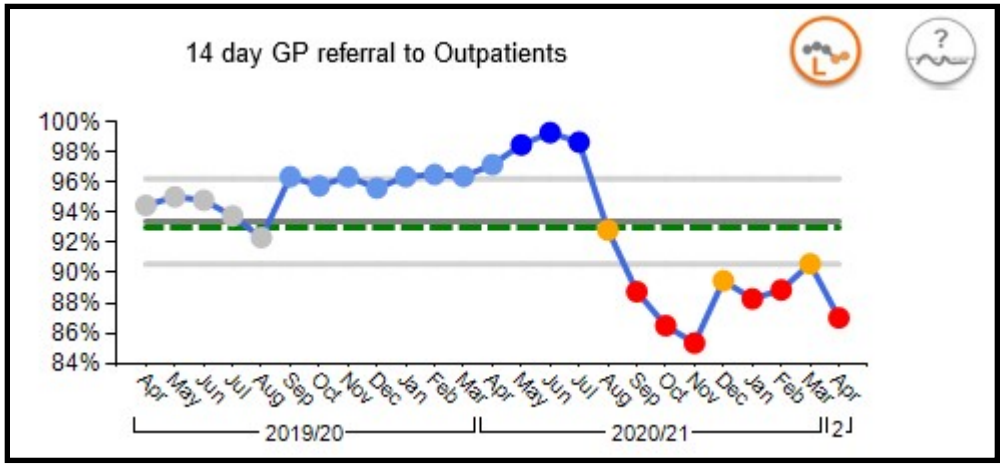
62 day GP referral to treatment



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%	87%	125	Apr 21		93%	90.6%	Mar 21	93%	87%	



Situation: 14 Day cancer performance is still below the compliance threshold, and also down on last month. Numbers of patients reported against this target fell when compared to March, with 97 patient breaches.

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. Increasing numbers of referrals and reduced capacity results in more breaches.

14 day target – failure of this target is primarily around patients who are on straight to test pathways for lower and upper GI. The endoscopy department continues to have issues around staffing and capacity. Gynae capacity in rapid access clinics is also constrained with performance against the 14 day standard dropping for this site. However, Urology, which has struggled with CT urogram capacity and referrals arriving without bloods has made a significant improvement this month, going up from 83.3% in March to 95.1% in April.

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. Extra lists are being provided on Saturdays to address demand. Latest update from endoscopy was on 4th June with waiting times for colonoscopy at 17 days for both men and women. OSM to remind staff of importance of marking requests "target".

Initial results from the Haematuria pathway audit have been presented to the CCG and while the problems still exists with no quick fix due to poor phlebotomy cover in primary care, urology performance has improved.

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. Poor documentation of breach reasons makes this very labour intensive.

Awaiting feedback from new Endoscopy Improvement group regarding the department utilisation, DNA rates and internal KPIs.

Ca. Improvement Project Manager now in post.

New gynae consultant expected to increase RA capacity.

Operations

Productivity

Analyst Narrative:

One indicator within this section is failing its assurance measure – Bed Occupancy ODGH. This indicator is also showing recent special cause concern and an action plan is included which provides further detail. No indicators within this section are assured. The Southport A&E Conversion rate is showing recent special cause concern due to increased rates during the Covid period, impacted by lower attendances and more poorly patients attending. Performance in the last two months is back to pre-Covid levels. The Length of Stay and both Stranded patient metrics are showing recent special cause improvement with a marked improvement in May. Outpatient slot utilisation continues its upward trajectory and is showing special cause improvement, with performance at its highest level for more than two years. In addition, the DNA rate continues to perform well and has further improved in May to performance below the third lower control limit.

Operational Narrative:

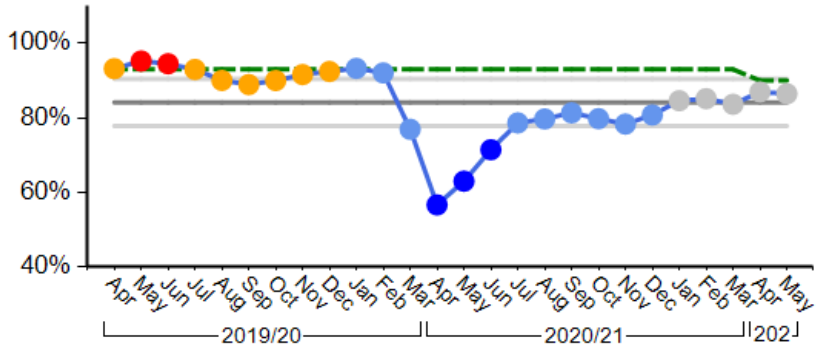
The Trust Outpatient Group has started and will meet monthly, specifically focussing on slot utilisation. Monthly targets will be set and there will be ongoing reviews of all clinics and templates to ensure the Medway system is up to date.

SDGH conversion rate – has reduced and back to pre-pandemic levels. SDEC, including CDU and ACU, continue to operate effectively. The aim from 18.6.21, is to transfer AMU into a 28 bedded footprint to improve flow through acute and urgent care pathways.

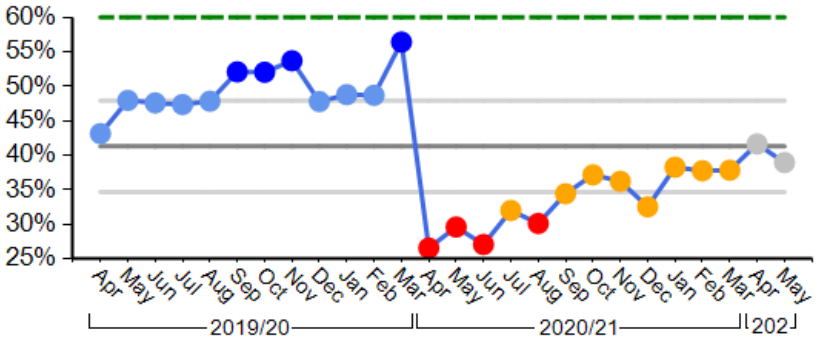
Please also refer to supplementary action plans for Bed Occupancy ODGH, LOS/Stranded Patients and Theatre Utilisation.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	90%	86.5%	N/A	May 21		90%	86.9%	Apr 21	90%	86.7%	?
Bed Occupancy - ODGH	60%	39%	N/A	May 21	L	60%	41.6%	Apr 21	60%	40.2%	F
Stranded Patients (>6 Days LOS)	163	149	149	May 21	L	163	160	Apr 21	163	309	?
Super Stranded Patients (>20 Days LOS)	53	41	41	May 21	L	53	47	Apr 21	53	88	?
OP Slot Utilisation	95%	94.7%	N/A	May 21	H	95%	93.9%	Apr 21	95%	94.3%	?
New:Follow Up	2.63	2.4	N/A	May 21		2.6	2.2	Apr 21	2.63	2.3	?
DNA (Did Not Attend) rate	7%	5.5%	1123	May 21	L	7%	5.7%	Apr 21	7%	5.6%	?
Theatre Utilisation - SDGH	75%	66.1%	N/A	May 21		75%	64.3%	Apr 21	75%	65.2%	?
Theatre Utilisation - ODGH	75%	66.9%	N/A	May 21		75%	69.7%	Apr 21	75%	68.1%	?
Southport A&E Conversion Rate	28%	21.7%	1160	May 21	H	28%	21.9%	Apr 21	28%	21.8%	?

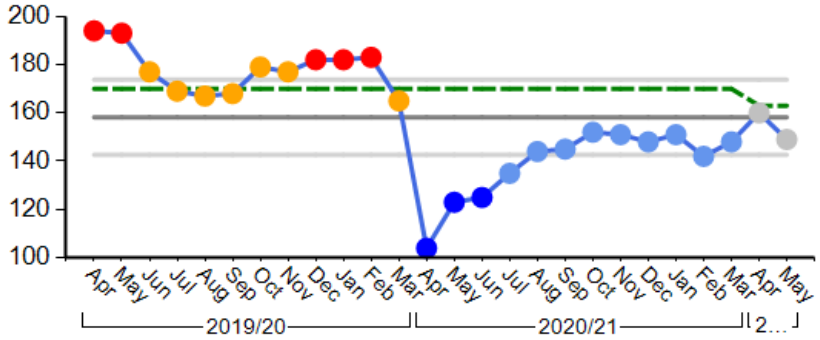
Bed Occupancy - SDGH



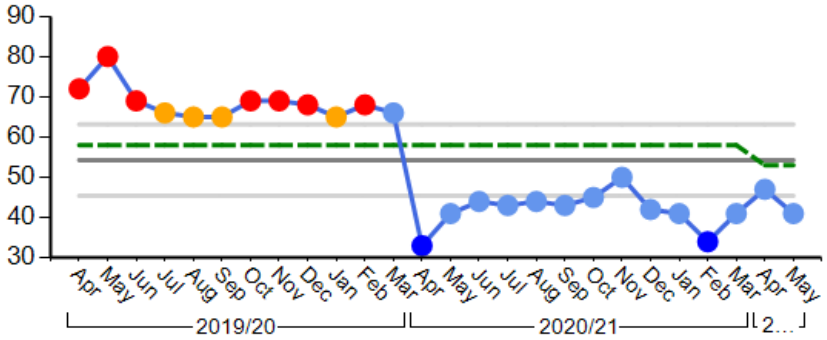
Bed Occupancy - ODGH



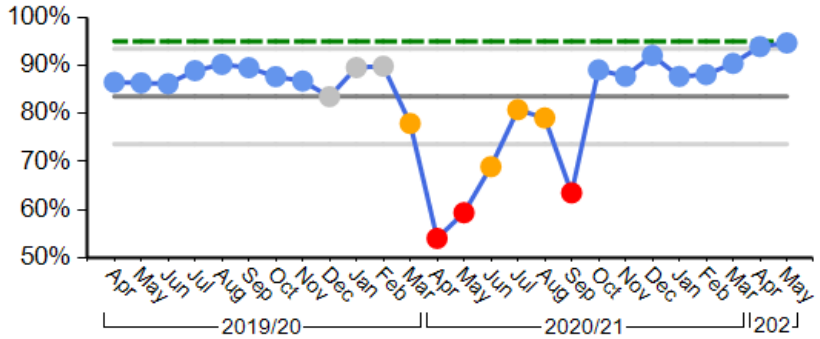
Stranded Patients (>6 Days LOS)



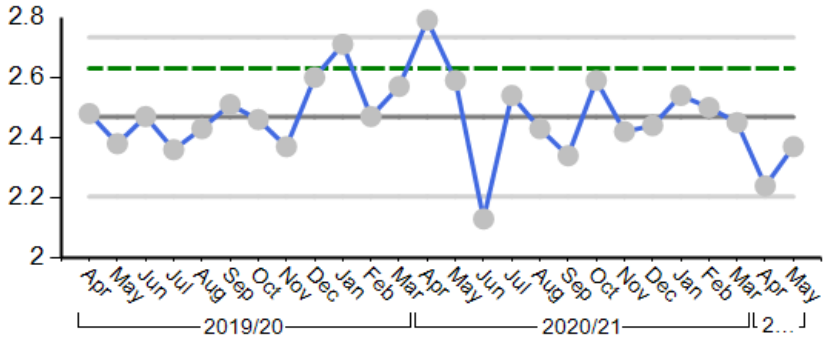
Super Stranded Patients (>20 Days LOS)



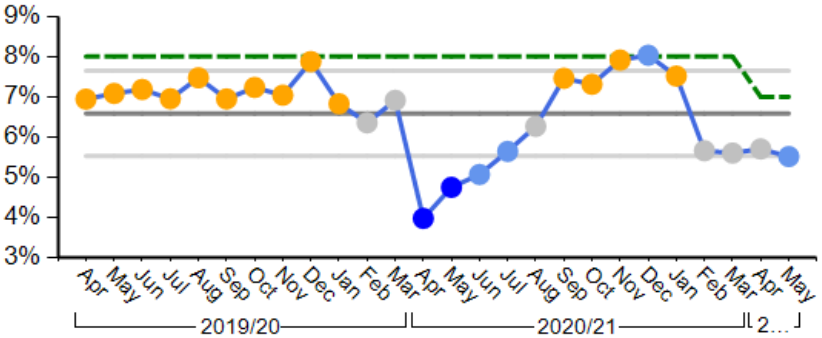
OP Slot Utilisation



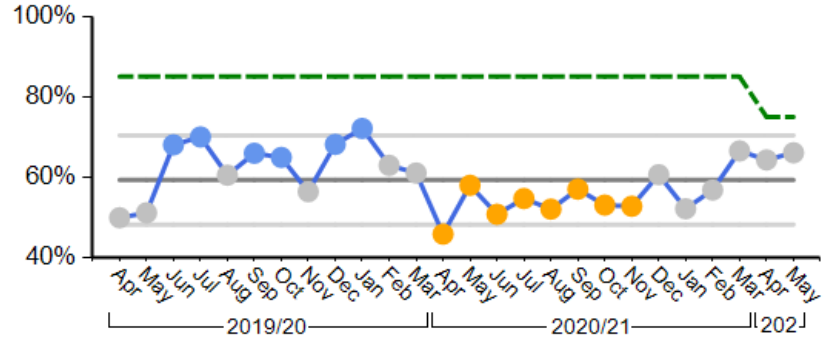
New:Follow Up



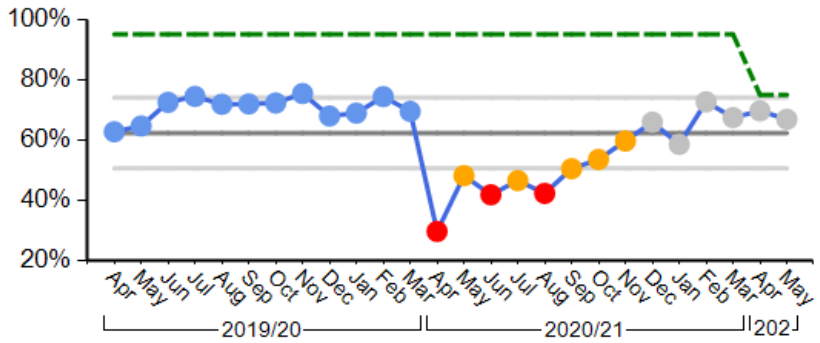
DNA (Did Not Attend) rate



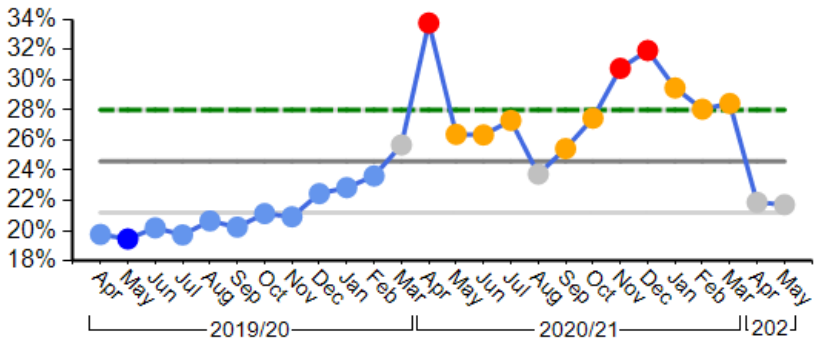
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



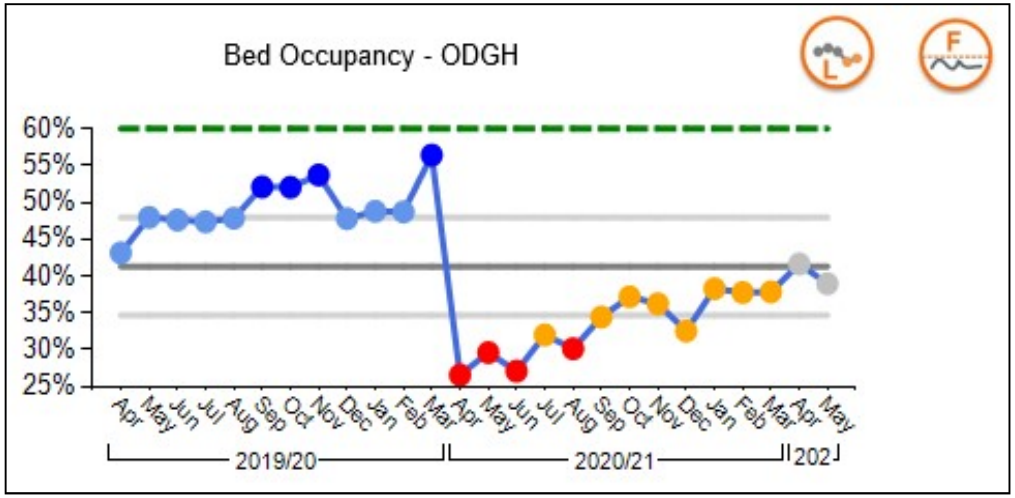
Southport A&E Conversion Rate



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%	39%	N/A	May 21	L	60%	41.6%	Apr 21	60%	40.2%	F



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 a marginal decline in occupancy in May but performance remains within control limits.

Issues:

H Ward remained closed in May due to lack of T&O Theatre capacity. Elective Orthopaedic lists were taken over by trauma. All activity run though E and F Ward in May.

Whilst F Ward was open in May, issues with ward staffing for Ophthalmology due to new starter delays, training and long term sickness meant staff had a resulting impact on occupancy.

Sickness/Maternity leave in Theatres staff meaning limited numbers of theatres running.

Overall occupancy on this site is impacted by Maternity and Paediatrics.

Actions:

Theatre lists running at 5 lists per day at ODGH.

New Ophthalmology recruit starting end of June which will impact F Ward occupancy.

Forward planning and micro managing lists at ODGH to maximise capacity within the workforce constraints.

Whilst 17 beds were removed on 11A, these have been replaced by opening beds on 10B, the new POCU and G Ward.

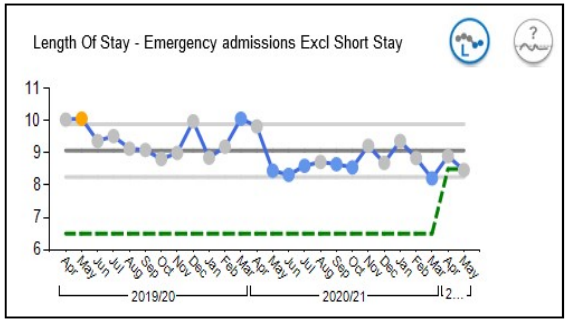
Mitigations:

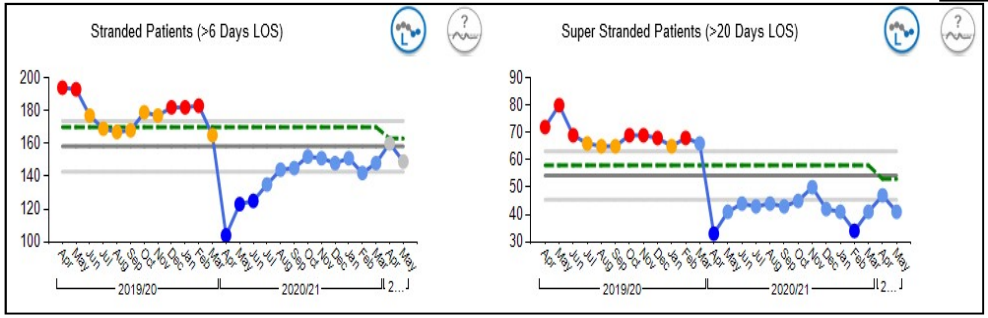
BI have created a number of internal reports to look at ward bed occupancy on a daily and monthly basis. It also shows the constitution of activity within each ward which helps to explain how each ward is being utilised for patient care.

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 - Emergency admissions Excl Short Stay	8.5	8.5	N/A	May 21		8.5	8.9	Apr 21	8.5	8.7	
Stranded Patients (>6 Days LOS)	163	149	149	May 21		163	160	Apr 21	163	309	
Super Stranded Patients (>20 Days LOS)	53	41	41	May 21		53	47	Apr 21	53	88	





Background:

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

Situation:

The plan of 6.5 has been updated to 8.5 to align with Model Hospital benchmarked average. Current average LOS is 8.5. Number of stranded and super-stranded patients has decreased in May.

Issues:

May 2021 saw high levels of attendances at A&E, with record levels w/c 24/05 including record levels of majors attendances.

Bed occupancy on the Southport site in high 90's.

Nurse staffing across all medical wards.

Reduced discharge lounge capacity due to essential ward safety works on the SDGH site.

Actions:

The Urgent and Emergency Care Improvement Group has identified key work streams to improve flow through the Trust. These include diagnostic response times, TTO response times, Board and Ward Round: Due Diligence, Bed Modelling and Staffing.

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.

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:

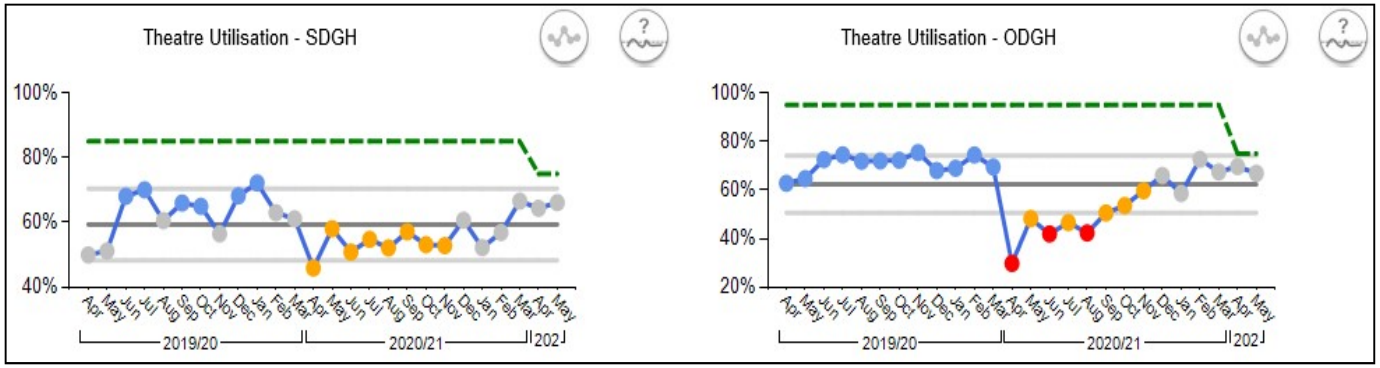
Patients are managed based on their "reason to reside"; when they no longer meet the range of conditions under this criterion, they must be placed into an alternative setting for discharge planning if they cannot be discharged to their own home.

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%	66.1%	N/A	May 21		75%	64.3%	Apr 21	75%	65.2%	
Theatre Utilisation - ODGH	75%	66.9%	N/A	May 21		75%	69.7%	Apr 21	75%	68.1%	



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. Both indicators showing variable performance, both above the mean in May.

Issues:

Utilisation in April at SDGH was impacted by bed pressures which resulted in an increase in cancelled operations.

ODGH lists were impacted by 5 elective cases needing to be cancelled to be replaced by additional trauma.

Theatre utilisation was impacted by late starts in May, with 57% of sessions starting late due to patients not being ready on the ward and Consultants being late for sessions. 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.

Implementation of the new surgical pathway to mitigate the likelihood of cancellation for bed capacity reasons.

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:

Several of the new finance indicators have been back-dated to include 2020/21 data this month. This has included updating both the pay and non-pay run rate figures to include the Covid cost centres. They had previously been removed for 2020/21 to provide more meaningful comparison to the previous year, but as they will continue going forward they will now be included. Both these indicators are failing their assurance measure and showing special cause concern although have reduced from a peak in March 2021.

The Bank and Agency Run Rate continues to show special cause concern although is on a downward trajectory from the January peak. The Year to Date Reduction in Premium Pay, whilst showing special cause concern, is much improved as a direct result of recruitment activity. Indicators showing recent special cause improvement are I&E surplus or deficit/total revenue, % Agency Staff (cost) and Cash Balance.

Operational Narrative:

The plan is break-even for H1 (1st half of the financial year).

A deficit of £257,000 has been incurred to the end of May.

The year-end forecast outturn is break-even.

Expenditure levels are consistent month on month but income has fallen marginally below plan in May.

Expenditure levels are expected to rise in the remainder of H1 (1st half of the financial year) as the elective programme is ramped up to restore activity. It is vital that other elements of expenditure are reduced in mitigation (e.g. COVID spend) as well as progress on the CIP.

Bank and agency costs have fallen to 16.4% of total pay costs which, although remaining high, reflect progress in recruitment and reduced COVID spend.

Agency costs were consistent with April (£0.9 million in May) with 70% of the costs attributable to medical staff. 70% of the medical staff agency resides within the Medical & Emergency Care CBU where Consultant vacancy rates are 30%.

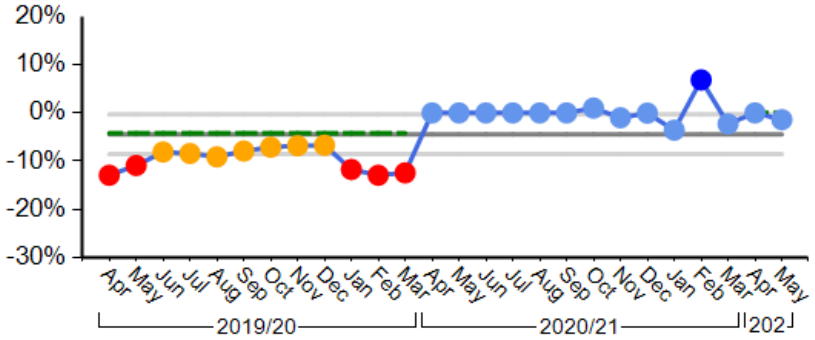
Premium rate pay expenditure (bank and agency) has reduced further in May by £0.1 million. International nurse recruitment and success in the appointment of Consultant medical staff is essential in order to reduce spend to sustainable financial levels.

The financial gap for H1 is £4.5 million (estimated £9.0 million for the full year before NHSE/I guidance on the H2 financial framework). The CIP programme will contribute towards this, alongside a number of other initiatives such as reducing COVID expenditure and delivering a contribution from the Elective Recovery Scheme (ERF). The CIP programme has identified a number of schemes and delivered £0.3 million savings at month 2 year to date.

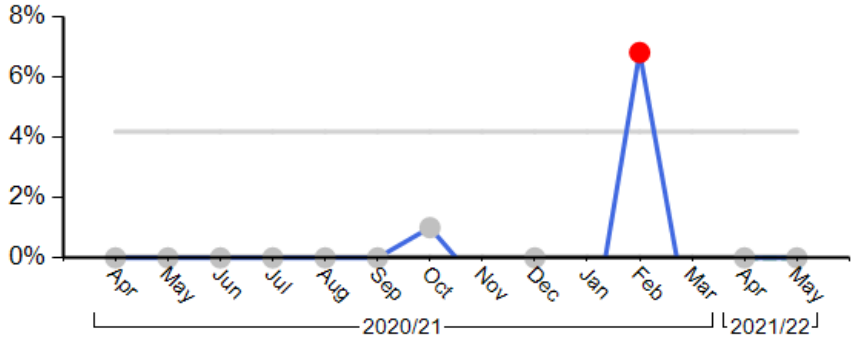
	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	0%	-1.4%	N/A	May 21		0%	0%	Apr 21	0%	-1.4%	
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	0%	N/A	May 21		0%	0%	Apr 21	0%	0%	

Pay Run Rate - Trust	£13,500K	£13500K	N/A	May 21			£13600K	Apr 21	£27,000K	£27,100K	
Non Pay Run Rate - Trust	£5,800K	£5800K	N/A	May 21			£5700K	Apr 21	£11,600K	£11,500K	
Year to date Budget in balance		No	N/A	May 21			No	Apr 21		Yes	
Budget in balance - forecast year end		Yes	N/A	May 21			Yes	Apr 21		Yes	
Bank & Agency Run Rate - Trust		£2207K	N/A	May 21			£2310K	Apr 21		£4,517K	
Bank & Agency Staff Run Rate (%)		16.4%	N/A	May 21			17%	Apr 21		16.7%	
Agency Staff Run Rate (Cost)		£900K	N/A	May 21			£900K	Apr 21		£1,800K	
% Agency Staff (cost)		6.7%	N/A	May 21			6.3%	Apr 21	5%	6.5%	
Year To Date Reduction in Premium Rate pay		-£400K	N/A	May 21			-£200K	Apr 21		-£400K	
CIP – Performance against Plan		£300K	N/A	May 21			£00K	Apr 21	£1,500K	£300K	
CIP – Forecast Outturn	£9,000K	£9000K	N/A	May 21			£4200K	Apr 21	£9,000K	£9,000K	
CIP on Target		No	N/A	May 21			Yes	Apr 21		No	
Capital Spend – Actual in Month		-£29K	N/A	May 21			£300K	Apr 21	£400K	£271K	
Capital Spend – Forecast Outturn		£6872K	N/A	May 21			£6872K	Apr 21			
Cash Balance		£7045K	N/A	May 21			£7170K	Apr 21			

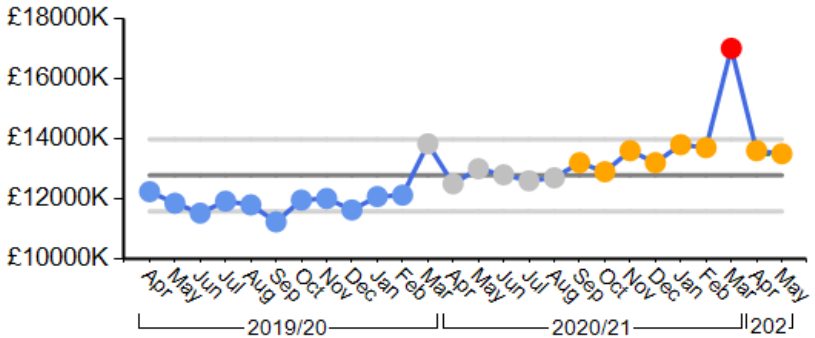
I&E surplus or deficit/total revenue



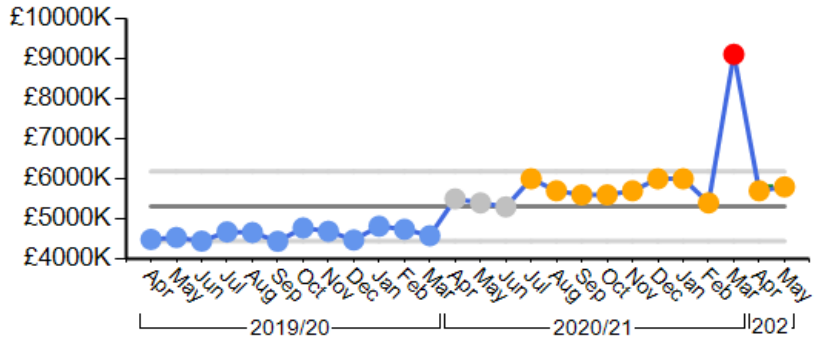
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



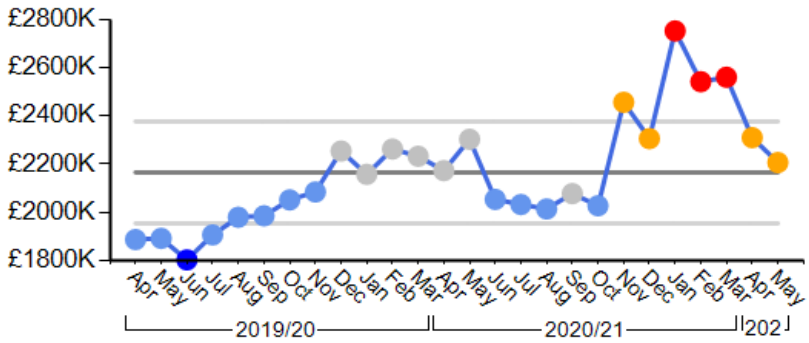
Pay Run Rate - Trust



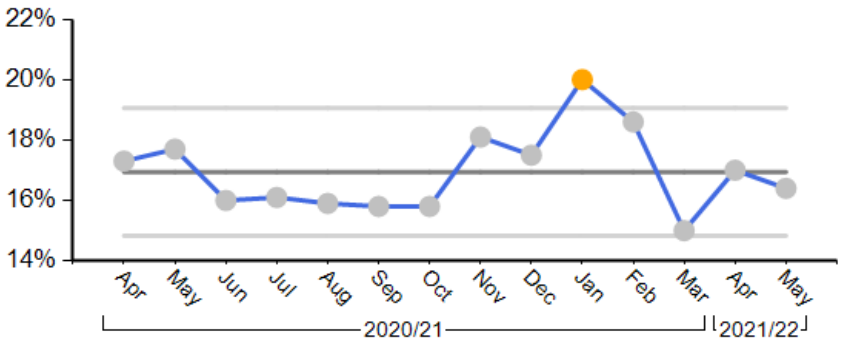
Non Pay Run Rate - Trust



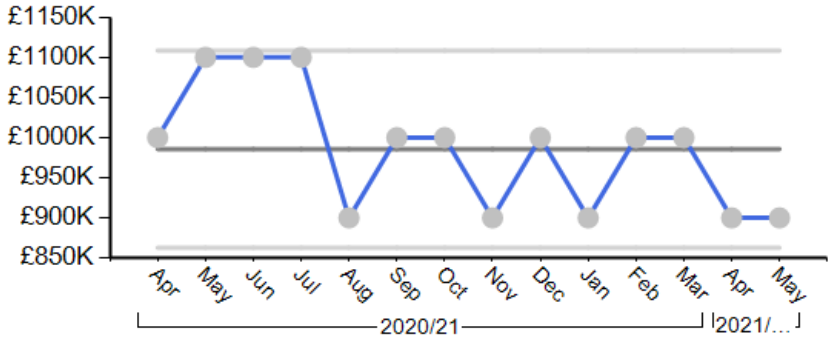
Bank & Agency Run Rate - Trust



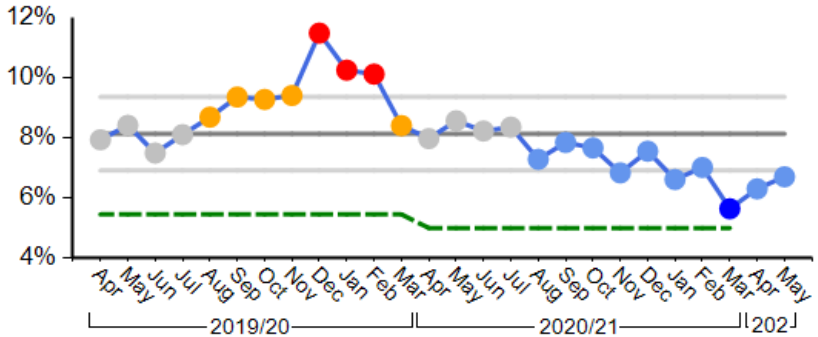
Bank & Agency Staff Run Rate (%)



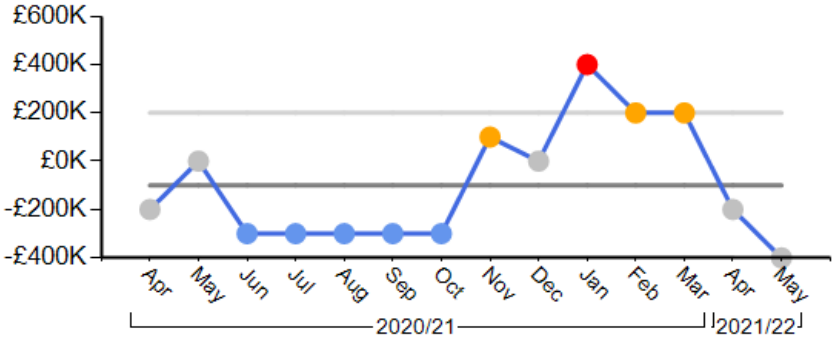
Agency Staff Run Rate (Cost)



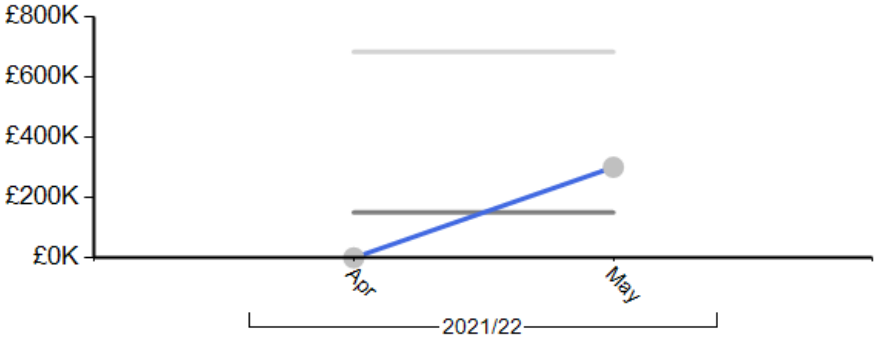
% Agency Staff (cost)



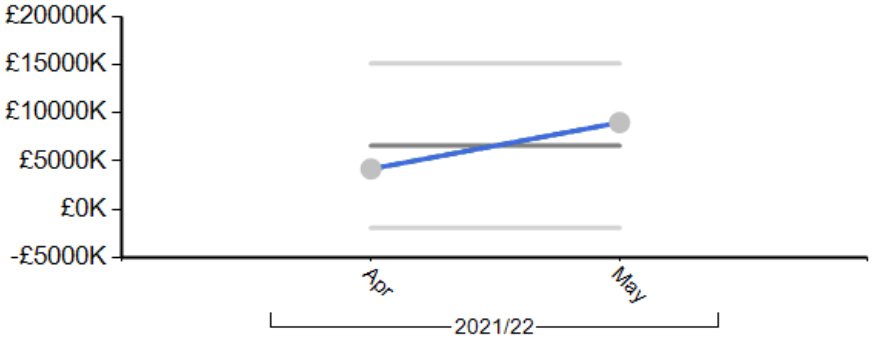
Year To Date Reduction in Premium Rate pay



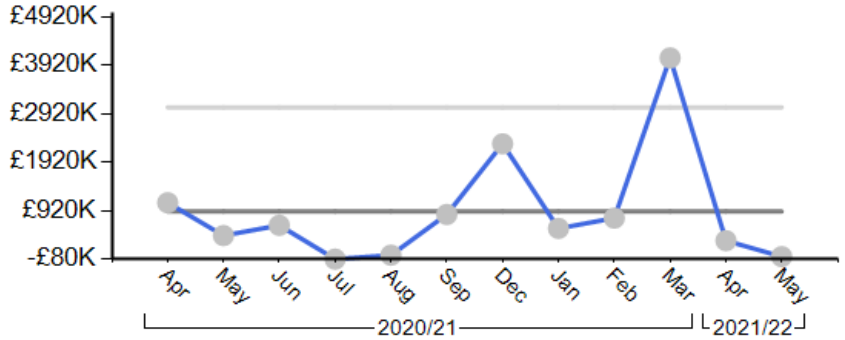
CIP – Performance against Plan



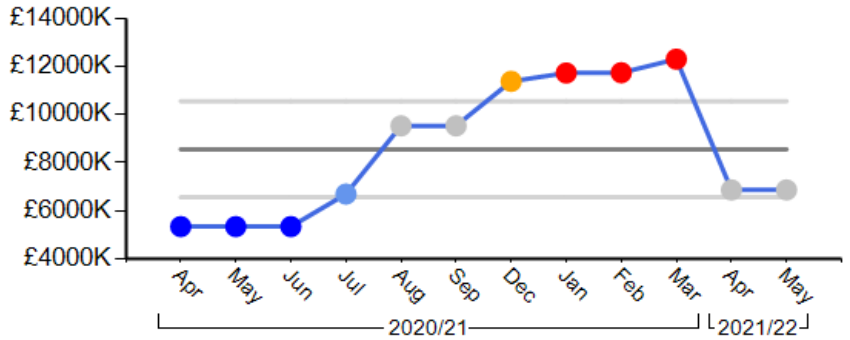
CIP – Forecast Outturn



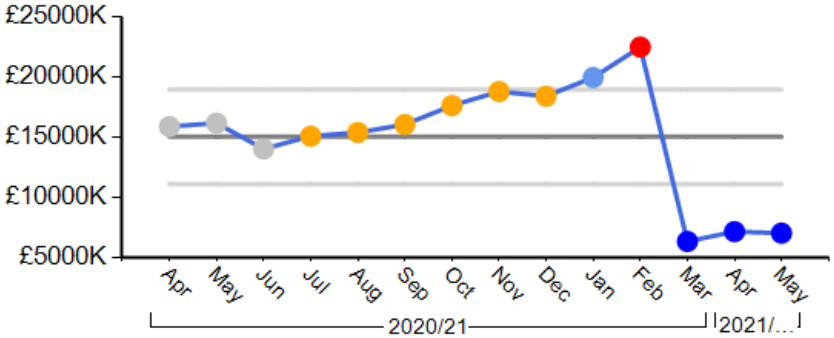
Capital Spend – Actual in Month



Capital Spend – Forecast Outturn



Cash Balance



Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB117/21**	**FOI Exempt**	**NO**
Report Title	**MONTH 2 FINANCIAL POSITION 2021/22**		
Executive Lead	John McLuckie, 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 May 2021 (month 2).

Executive Summary

The Trust's break-even plan relies on the £4.5 million gap in H1 (1st half of the financial year) being mitigated by CIP, underspend against reserves and a contribution from the Elective Recovery Fund (ERF).

- The H1 gap after ERF contribution of £0.8 million is £3.7 million.
- In month 2 a deficit of £266,000 has been incurred (£257,000 deficit year to date (YTD)).
- The month 2 YTD performance suggest the Trust is not heading for a deficit of £3.7 million due to the impact of ERF, CIP, and other favourable expenditure variances.
- CIP savings of £287,000 have contributed to the month 2 YTD position.
- A more detailed forecast outturn for H1 will be developed after Quarter 1 close.

Recommendations

The Board to asked to **note**:

- A deficit of £257,000 incurred at month 2 YTD.
- The importance of ERF to break-even.
- The areas of focus to reduce expenditure.

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	John McLuckie

Finance Report – Month 2 2021/22

1. Purpose

1.1. This report provides the Board with the financial position for May 2021 (month 2).

2. Executive Summary

2.1. The Trust's break-even plan relies on the £4.5 million gap in H1 (1st half of the financial year) being mitigated by CIP, underspend against reserves and a contribution from the Elective Recovery Fund (ERF).

2.2. The H1 gap after ERF contribution of £0.8 million is £3.7 million.

2.3. In month 2 a deficit of £266,000 has been incurred (£257,000 deficit year to date (YTD)).

2.4. The month 2 YTD performance suggest the Trust is not heading for a deficit of £3.7 million due to the impact of ERF, CIP and other favourable expenditure variances.

2.5. CIP savings of £287,000 have contributed to the month 2 YTD position.

2.6. A more detailed forecast outturn for H1 will be developed after Quarter 1 close.

3. Income & Expenditure for Month 2

3.1. Although the financial framework has only been formalised for H1 the Trust's 2021/22 financial plan has been set based on H1 X 2.

3.2. The gross financial gap for H1 is £4.5 million (£9 million gap for the full financial year).

3.3. The plan assumes the ERF will contribute £0.8 million in H1 which reduces the financial gap to £3.7 million (estimated £7.4 million for the full financial year)

3.4. The Trust must establish schemes to close the £3.7 million gap in order to break-even in H1.

3.5. It is evident that CIP schemes alone will not generate this level of savings in the short term. Therefore, there are a number of options to consider in order to break-even in H1 and these are considered further in the report.

3.6. The following table illustrates performance to date for month 2:

Table 1 Income & Expenditure Account – May 2021

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	177,256	29,587	29,583	(3)	14,393	14,391	(2)
PP, Overseas & RTA	616	103	102	(1)	51	49	(2)
Other Income	10,118	1,714	1,721	7	858	930	72
NHSE/I Top up	42,493	7,082	6,853	(230)	3,899	3,670	(230)
Total Operating Income	**230,483**	**38,485**	**38,258**	**(227)**	**19,202**	**19,040**	**(162)**
PAY	(161,045)	(26,962)	(27,034)	(72)	(13,482)	(13,476)	6
NON PAY	(65,420)	(10,932)	(10,844)	88	(5,464)	(5,507)	(43)
Total Operating Expenditure	**(226,464)**	**(37,894)**	**(37,878)**	**16**	**(18,946)**	**(18,983)**	**(37)**
Operating surplus/deficit	**4,019**	**591**	**380**	**(211)**	**257**	**57**	**(199)**
NET FINANCE COSTS	(4,019)	(670)	(663)	6	(335)	(332)	3
Retained Surplus/Deficit	**(0)**	**(78)**	**(283)**	**(205)**	**(78)**	**(275)**	**(196)**
Technical Adjustments	0	0	26	26	0	9	9
Break Even Surplus/(Deficit)	**(0)**	**(78)**	**(257)**	**(179)**	**(78)**	**(266)**	**(187)**

3.7. The Trust has delivered a deficit of £266,000 in month 2 (£257,000 deficit YTD).

3.8. The opening annual budget has been profiled equally across 12 months although some in year issues result in a £78,000 deficit plan at month 2 YTD. These will be rectified in month 3 so that the profiled budget is break-even each month within H1.

3.9. On the face of it the key issue driving the YTD deficit position would appear to be a shortfall in income of £230,000.

3.10. This is a result of activity underperformance which has generated a shortfall against ERF income (£487,000 achieved month 2 YTD against a budget of £717,000 at month 2 YTD). This is further explained in section 6 of this report.

3.11. The ERF income earned to date is as a result of outpatient activity recovery, mainly through virtual clinics, with low levels of associated expenditure. Elective activity is below the national trajectory levels.

3.12. The above table suggests that expenditure is being contained within the resources available in May, but the Month 2 YTD budget includes two months of the ERF budget (£454,000) with marginal expenditure (c £10,000) incurred as most of the budget is associated with the elective programme. Therefore, other elements are overspending.

3.13. The following section provides a more useful analysis of the financial performance to date through a bridge analysis of the main issues.

4. Bridge of Month 2 YTD financial performance

4.1. The following bridge identifies the main financial drivers of the deficit:

Table 2 Financial Bridge

	M2 YTD	
	£000	Comment
Plan Surplus/(deficit)	**(1,500)**	H1 £4.5M (before CIP/ERF) divided by 6 X 2
Income shortfall	(83)	Non NHS income (catering,car park)
CIP actual delivery	287	H1 requires £3.7M excluding ERF contribution CIP = £1.2M Month 2 YTD
ERF contribution	477	Income £487k; Exp £10K marginal - outpatients
COVID overspend	(56)	£633k budget; £689k actual
Scientific, Therapies underspend	240	Therapy services (Physio/OT) and radiology
Non Pay underspend	240	Mainly due to lower clinical supplies & sevices in CBU's incl £100k drugs.
Reserves profiled into M2 YTD	1,531	excluding ERF and COVID
Medicine & Emergency Care CBU	(1,393)	Medical staff £964K; Nursing staff £429K
Actual Surplus/(deficit)	**(257)**	

4.2. The above table illustrates where the organisation now needs to focus its efforts. Each issue needs to be reviewed and addressed with a view to assessing the financial impact for the remainder of H1.

4.3. Non-NHS income is not recovering to the levels set in the H1 plan. This is not evident in table 1 above as non-recurrent income of £90,000 has been received in month 2 as part of the CIP programme. Both car parking and catering levels are still underperforming, and we expect this to continue for the remainder of H1.

4.4. One of the key issues is the potential for additional funding within the Elective Recovery Fund (ERF). Already a contribution of £477,000 has been made at month 2 YTD. Although a contribution of £0.8 million has been factored into the H1 plan it appears there may be more funding available from this source providing the elective activity can recover and the income is available within the system pot (see section 6). Month 2 YTD ERF income of £487,000 still needs to be confirmed before we are certain it will be paid.

4.5. We have already seen a reduction in monthly COVID expenditure from March through to May, but this needs to reduce further in order to improve the financial position.

4.6. The H1 plan includes £1.9 million for COVID which amounts to £316,000 per month.

4.7. COVID expenditure reduced from £397,000 in month 1 down to £292,000 in May.

4.8. Unless vacancies are significantly recruited to the Scientific & Technical staff underspend will continue at the same rate.

4.9. It is expected that the Trust's non-pay underspend will not continue as activity is recovered.

4.10. A detailed review of the Medicine & Emergency Care CBU budget has commenced with a view to fully understanding the recurrent nature of any residual COVID and winter schemes. The impact of frailty needs to be a part of this review.

4.11. The CBU's medical staff overspend is mainly within Emergency Care CBU (£0.5 million) and General Medicine (£0.4 million). High vacancy rates are driving bank and agency costs of £1.2 million at month 2 YTD. The CBU's medical staff budget is 40% overspent at month 2 YTD.

4.12. The CBU's nursing staff overspend is mainly within Emergency Care CBU (£0.1 million), General Medicine (£0.2 million) and Specialist Medicine (£0.2 million). Bank and agency costs are £1.2 million at month 2 YTD. The CBU's nursing staff budget is 11% overspent at month 2 YTD.

4.13. Costs of £55,000 (£332,000 full year estimate) associated with potential Agenda for Change rebandings for maternity (band 3 to 4) have been included in the month 2 YTD position. Recent discussions with HR colleagues have clarified this issue and this accrual will be reversed in

month 3 as this is no longer a risk.

4.14. The Trust is currently spending circa £2.2 million per month on bank and agency, mainly across nursing and medical staff.

4.15. The biggest opportunity for savings resides within nurse agency and medical bank and agency as these attract the largest premium compared to substantive pay costs.

4.16. We are beginning to experience lower nurse agency costs which is in part due to the success of both international nurse recruitment and the nurse incentive scheme in previous months. Despite this our nurse band 5 vacancies remains high at 20%.

4.17. A 16% vacancy rate in Consultant medical staff is also driving high agency costs.

4.18. In summary, the current expenditure run rate will result in a H1 deficit so remedial action is now required against the issues identified.

5. Business Unit Budget Performance

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

Table 3 Business Unit Budgetary Performance

	Annual	Year to Date			In Month - Month 2		
Business Unit	Budget	Budget	Actual	Var	Budget	Actual	Var
	£000	£000	£000	£000	£000	£000	£000
Medicine & Emergency Care	(55,816)	(9,302)	(10,641)	(1,339)	(4,670)	(5,370)	(700)
Planned Care	(58,161)	(9,693)	(9,467)	226	(4,818)	(4,750)	68
Specialist Care	(42,164)	(7,027)	(6,922)	105	(3,513)	(3,519)	(6)
Corporate	201,959	33,623	35,008	1,385	16,772	17,443	670
Finance	(6,770)	(1,128)	(1,021)	107	(564)	(473)	91
Estates & Facilities	(16,845)	(2,807)	(2,869)	(62)	(1,404)	(1,474)	(70)
Human Resources	(3,121)	(520)	(502)	18	(260)	(253)	7
Nursing & Midwifery	(3,848)	(641)	(707)	(66)	(330)	(332)	(2)
Medical Director	(9,019)	(1,503)	(1,497)	6	(752)	(750)	2
Strategy	(2,196)	(410)	(976)	(566)	(205)	(456)	(251)
Financing Costs	(4,019)	(670)	(663)	7	(335)	(332)	3
Total	**0**	**(78)**	**(257)**	**(179)**	**(79)**	**(266)**	**(187)**

5.2. Whilst analysing performance in the above table it is important to remember that no reserves have been allocated into business units in month 1 or month 2. All reserves remain within Corporate but will be distributed in month 3 following ETM approval.

5.3. Medicine & Emergency Care CBU's adverse variance is mainly driven by the premium rate expenditure as explained in section 4.

5.4. Even after the allocation of reserves the Medicine & Emergency Care CBU is expected to be adverse to budget.

5.5. Planned Care is underspent in month, mainly within theatres, due to services not yet fully restored to 2019/20 activity levels.

5.6. Corporate contains the reserves which will only be allocated from month 3 onwards once they have been prioritised by the Executive Team taking into account the robustness of the CIP

Programme. This is the main reason for the underspend.

5.7. Finance favourable variance relates to a £90,000 income CIP which will be removed to CIP in month 3.

5.8. Nursing & Midwifery adverse variance relates mainly to international nurse recruitment costs which do not yet have a budget allocated from reserves. This will be rectified in month 3.

5.9. Strategy adverse variance relates to COVID expenditure which does not yet have a budget allocated from reserves. Once actioned in month 3 then this budget will deliver a favourable variance due to vacancies within the Programme Management Office (PMO).

6. Activity Performance and Elective Recovery Fund (ERF)

6.1. The estimated ERF contribution towards the financial gap is £0.8 million in H1.

6.2. This is derived from income of £2.1 million and expenditure of £1.3 million.

6.3. The table below illustrates income performance at month 2:

Table 4 ERF Income forecast

	Apr-21			May-21			May 21 YTD
	National Trajectory	Trust Actual	ERF Income	National Trajectory	Trust Actual	ERF Income	ERF Income
	%	%	£000	%	%	£000	£000
Elective	70	66	(88)	75	70	(103)	(191)
Outpatient	70	95	399	75	92	279	678
Total			**311**			**176**	**487**

6.4. Income of £487,000 has been accrued month 2 YTD in relation to ERF income.

6.5. As there was only marginal expenditure associated with the outpatient activity the contribution at month 2 YTD is £477,000.

6.6. As the H1 financial plan is profiled equally across six months the planned benefit from ERF was £233,000 (£800,000/6). The ERF month 2 YTD contribution is ahead of plan and this is derived from outpatient performance.

6.7. The elective plan was based on delivery of additional activity through Renacres, HBS and WLI's. YTD this activity has not been delivered explaining the underperformance against income plan.

6.8. The Trust's ERF income is dependent on HCP system performance although, at the time of writing this report, this information has not yet been communicated. It is expected that the monthly income figure will be communicated in a timelier manner from month 3 onwards.

6.9. In addition, our ERF income calculations still have to be ratified once NHSE/I have shared with us the methodology for the month1 payment.

6.10. Furthermore, we understand there may be additional activity that can be counted against the ERF which wouldn't have under PbR rules e.g. Attend Anywhere non-consultant activity. The Committee will be updated once this has been confirmed.

7. CIP

7.1. The planning for CIP commenced in December 2020 when an indicative 3.5% target was set based on size of expenditure budget (total £7.4 million). This was set without being aware of the arrangements for the 2021/22 financial regime. See table 5 below.

7.2. A second wave of COVID resulted in the cancellation of all non-essential meetings with CBU's channelling all their resources into dealing with the pandemic across the winter period.

7.3. In the meantime, NHSE/I postponed the 2021/22 planning round, and it was suggested that a modest CIP would be required although the financial regime remained unclear.

7.4. The Trust initially focussed on developing Corporate CIP's (during Quarter 4 of 2020/21) and during Quarter 1 of this financial year CBU's have also refocussed their efforts on the CIP programme.

7.5. The Trust H1 break-even plan assumes a financial gap of £4.5 million is mitigated by ERF (£0.8 million) and other measures inclusive of CIP (£3.7 million).

7.6. The initial target identified in 7.1 above (£7.4 million in 2021/22) is, therefore, consistent with the financial gap for H1 (£3.7 million).

7.7. The table below contains the performance to date:

Table 5 CIP Performance

CBU	CIP Target H1	Actual M2	FOT H1	FOT H1&H2	FOT H1&H2
	CYE	CYE	CYE	CYE	FYE
	£'000	£'000	£'000	£'000	£'000
Corporate	221	0	0	0	0
Estates & Facilities	335	3	9	18	18
Finance	101	120	121	123	4
HR	56	13	13	15	6
Medical Director	163	0	0	0	0
Medicine & Emergency	1,024	0	485	975	975
Nursing & Midwifery	61	32	44	44	0
Planned Care	1,027	12	262	600	605
Procurement	12	50	169	356	172
Strategy	36	18	54	109	109
Specialist & Support	641	39	87	153	121
Total	**3,677**	**287**	**1,244**	**2,393**	**2,010**

7.8. Note the CIP targets were indicative and calculated in December 2020 for the full financial year. H1 target is half of the full year target.

7.9. Procurement schemes mainly relate to savings in CBU's.

7.10. Given the late start to the CIP planning process some schemes identified will not deliver from 1st April. Therefore, it is important that other initiatives contribute whilst CIP schemes are embedded and are delivering recurrent savings.

8. Cash

8.1. The cash balance at the end of May was £7,045,000.

8.2. This was slightly below the forecast of £7,399,000 shared with the Board last month.

8.3. There is nothing significant to highlight to the Board relating to the shortfall against the cash target which was a combination of slightly lower cash inflows and slightly higher cash outflows.

8.4. For H1 there's unlikely to be any requirement for the Trust to borrow money for working capital.

9. Debtors

9.1. Overall debt has reduced significantly from £4.4 million last month to £3.2 million this month.

9.2. There were reductions in both NHS (reduced by £1m) and non-NHS debt (reduced by £0.2m).

9.3. The position on the top 10 debt greater than 1 year shows a slight improvement to last month but overall, the total value of debt greater than 1 year has risen marginally.

9.4. There is a focus on reducing this level of debt and the Finance teams are working through this in partnership with SBS.

9.5. The Board will start to see progress in this area over the coming months.

10. Capital

10.1. Year to date spend is now £280,000 which represents only 4.1% of the annual plan.

10.2. In month, expenditure is negative (-£29,000) driven by a larger VAT recovery on the 2020/21 A&E works than originally forecast.

10.3. The main issue to highlight is the revised 2021/22 plan which is detailed in the Capital Investment Group AAA report.

11. Conclusion

11.1. The Trust is behind plan at Month 2.

11.2. Break-even is a challenging target for H1.

11.3. ERF performance, for the remainder of H1, will be critical in determining whether beak-even is achievable.

11.4. Also, current monthly expenditure rates need to reduce, and the main areas of focus will be COVID and temporary staffing costs within Medicine & Emergency Care CBU.

11.5. Further progress on CIP is required to deliver H1 but is critical in readiness for H2.

12. Recommendation

12.1. Board to note

- A deficit of £257,000 incurred at month 2 YTD.
- The importance of ERF to break-even.
- The areas of focus to reduce expenditure.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	28 JUNE 2021
LEAD:	DR DAVID BRICKNELL

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The College report into past orthopaedic shortcomings has now been received and actioned. It highlights significant substandard past care, but the Board can receive assurance that all recommendations have been actioned. The committee is reviewing aspects of clinical governance in general in the light of the findings.

ADVISE

- Planning has taken place to be able to respond rapidly if the current rise in Covid-19 infections becomes more severe, and planning in relation to a possible surge in Paediatric respiratory issues later in the year is also underway.
- In relation to both the backlog and lost to follow up programmes the method of risk stratification, harm review and prioritisation is now agreed and in place, with the resultant minimisation of risk of harm to patients. The trajectories of these programmes have been agreed with the CCGs.
- The numbers and severity of hospital acquired pressure ulcers is not where we would wish it to be, but with a return to normal patterns of care there is a renewed focus on reducing the incidence.

ASSURE

- The Quality Priorities improvement plan for the current year is now in place, subject to clarification on some medicine's management data and the related Comms programme.
- Despite record levels of attendances at A&E, the reorganisation of the department has enabled it to cope with minimal delay, no corridor care, and good ambulance hand overs. Exceptional work on safe discharge has led to availability of beds to meet demand and a reduction in stranded patients.
- The CNST report in relation to Maternity can be recommended to the Board for submission, subject to clarification on a matter of planning for possible recruitment.
- Recommend approval of Health and Safety Annual Report, noting the specific work done in relation to fire safety and the maintenance of standards despite the pressures of Covid-19.
- IPC Board Assurance report is supported, and the Annual report is approved, noting that we had achieved a world first in using pop up isolation units in a clinical setting and were leaders in implementing between bed screening.
- The Quality Accounts were greatly improved in the final edition and have received support in the Stakeholder presentation and were therefore approved for submission.
- The annual R&D report was approved, noting the significant achievements in recruiting to national trials.

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

Review of the Risk Register: No action taken

Quality

Harm Free

Analyst Narrative:

One indicator is currently assured; Care Hours per Patient Day (CHPPD). This indicator continues to perform ahead of plan in May. Three indicators are showing recent special cause improvement; Never Events, StEIS and WHO Checklist. Performance on all other indicators is intermittent. Although not statistically significant, Safe Staffing has reduced in May and has failed to achieve the 90% target.

Operational Narrative:

StEIS - Three incidents were reported on the Strategic Executive Information System (StEIS) in May 2021. Two of these are from within our Maternity department and one relates to a Regulation 28 following a coroner's inquest. All three are being investigated.

HAPU – the three category 3 incidents are under investigation and will be presented to the Harm Free Care panel. Of the six category 2 HAPU's reported, one has been investigated. This case showed there were some lapses in documentation to support actions taken and appropriate action plans are now in place e.g. staff to attend SSKIN bundle refresher and share at ward huddle to reflect on required documentation. The remaining five cases are currently being investigated.

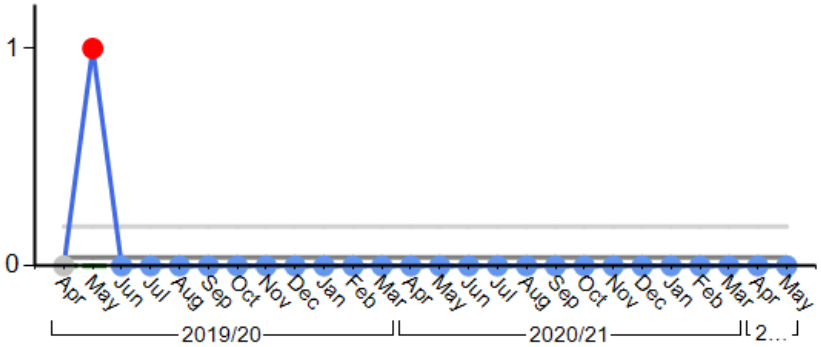
A piece of work to review processes around Fractured Neck of Femur repair within 36 hours has resulted in a significant increase in performance and achievement of the target in May.

Care Hours per Patient Day performance reporting at slightly below trust average (8.9).

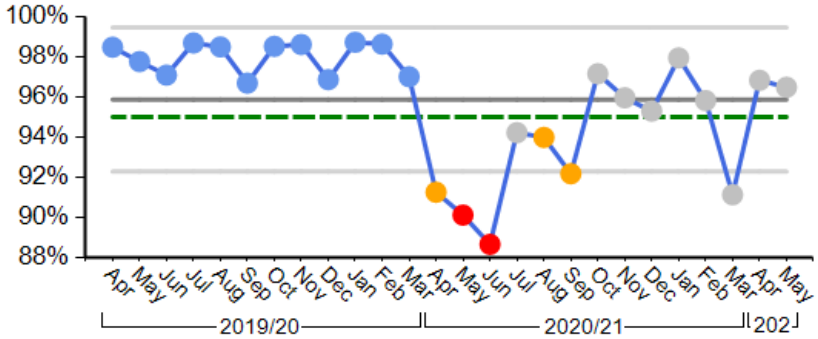
We continue to monitor fill rate to ensure we maintain safe staffing daily with May reporting safe staffing at 89% against the national target (90%). The reporting template requires update against recent nursing establishment reviews and recent ward reconfigurations to reflect updated planned versus actual staffing -May does not therefore reflect these updates. This work will be completed for June reporting.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	May 21		0	0	Apr 21	0	0	
VTE Prophylaxis Assessments	95%	96.5%	137	May 21		95%	96.8%	Apr 21	95%	96.6%	
Fractured Neck of Femur - Operated on within 36Hours	85%	89.3%	25	May 21		85%	82.1%	Apr 21	85%	85.7%	
WHO Checklist	100%	100%	0	May 21		100%	100%	Apr 21	100%	100%	
Safe Staffing	90%	88.6%	N/A	May 21		90%	92.8%	Apr 21	90%	90.7%	
Care Hours Per Patient Day (CHPPD)	7	8.9	N/A	May 21		7	9	Apr 21	7	9	
StEIS	0	3	3	May 21		0	2	Apr 21	0	5	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.5	6	May 21		0.5	0.3	Apr 21	0.45	10	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.2	3	May 21		0.1	0	Apr 21	0.1	3	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.9%	6	May 21		2.1%	0.8%	Apr 21	2.1%	0.9%	
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.1	1	May 21		0.1	0.2	Apr 21	0.1	0.1	

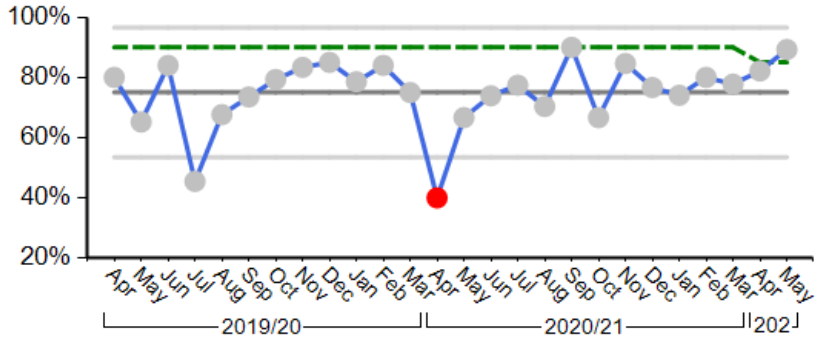
Never Events



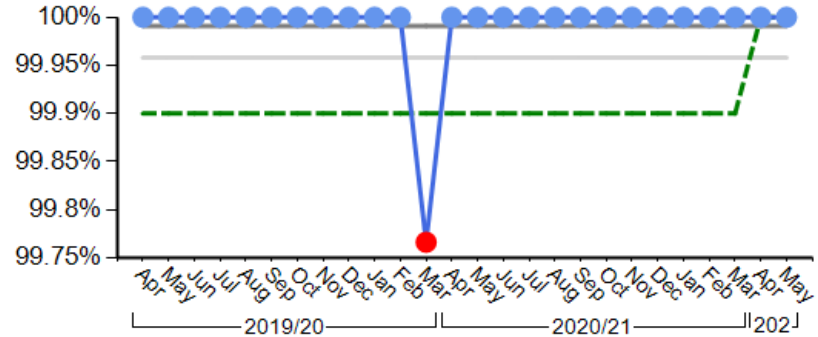
VTE Prophylaxis Assessments



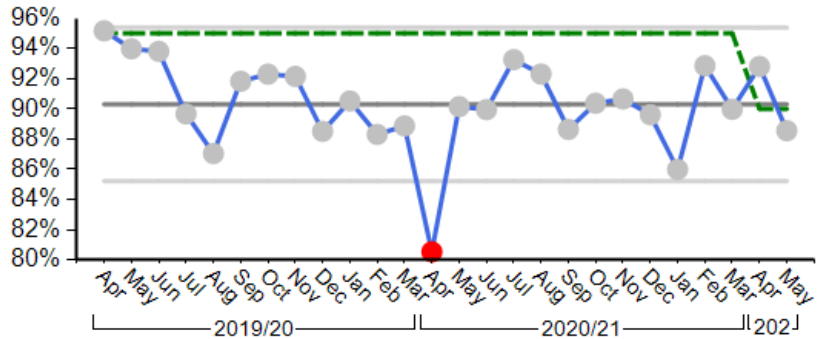
Fractured Neck of Femur - Operated on within 36Hours



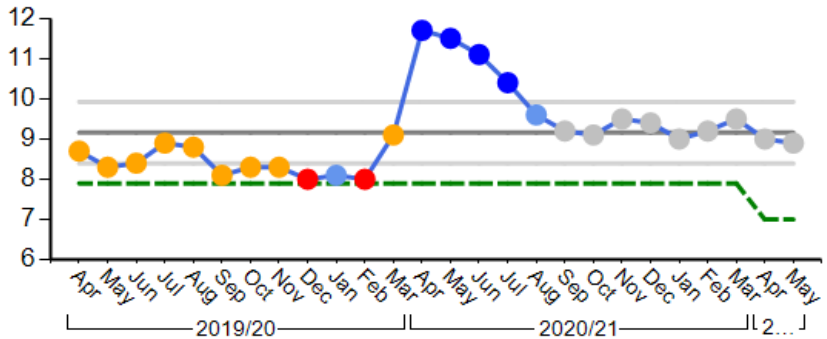
WHO Checklist



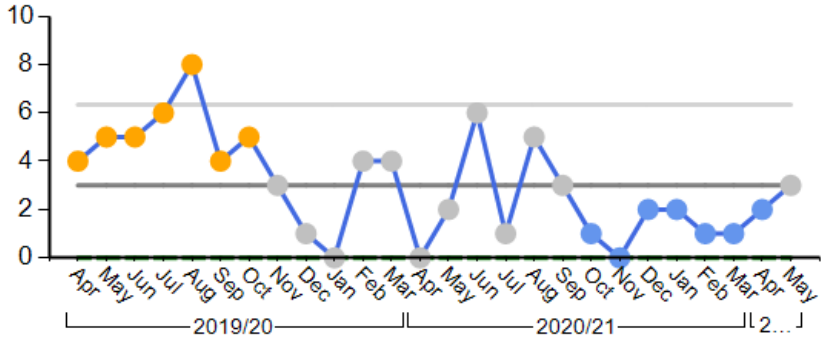
Safe Staffing



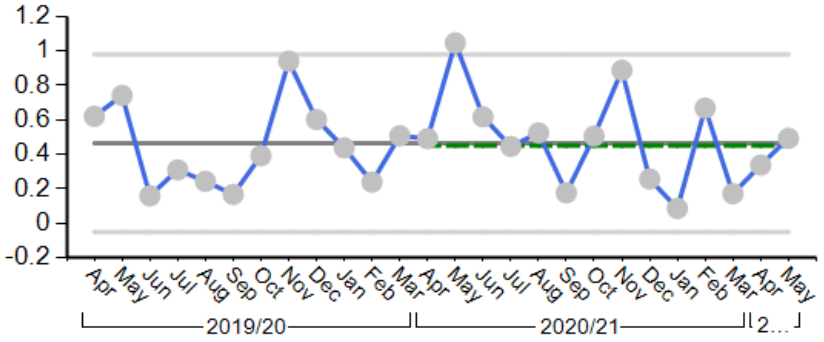
Care Hours Per Patient Day (CHPPD)



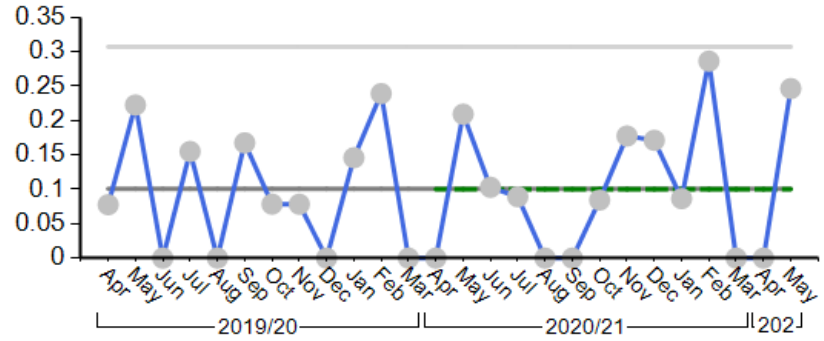
StEIS



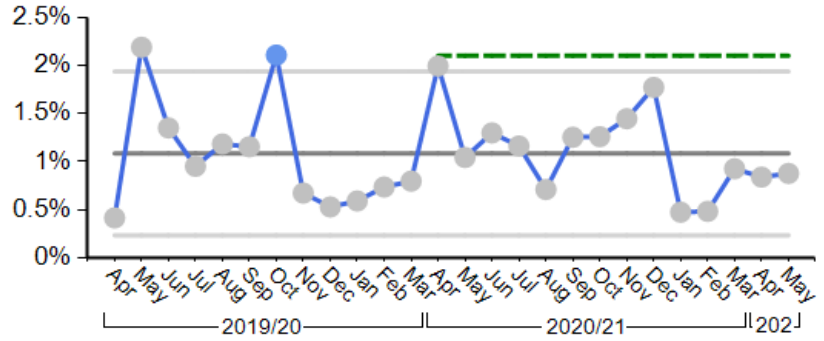
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



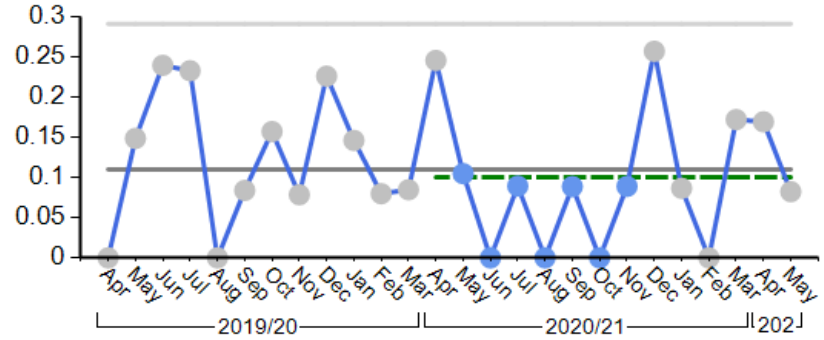
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



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:

No indicators within this section are assured but equally none are failing, with intermittent performance on all metrics. Following a peak in April, there has been a decrease in the number of C.diff infections in May although it remains above the target.

Operational Narrative:

No MRSA infections were reported in month.

Four C.diff infections in May; two were Hospital Onset Hospital Acquired (HOHA) from wards 7A and 11A. Both have been investigated and there were no apparent lapses in care. Two Community Onset Hospital Acquired (COHA) infections were reported, both patients were on ward 15A previously. Both have been investigated, one had no identified lapses in care, one identified a lapse due to a delay in treatment when admitted to 7A.

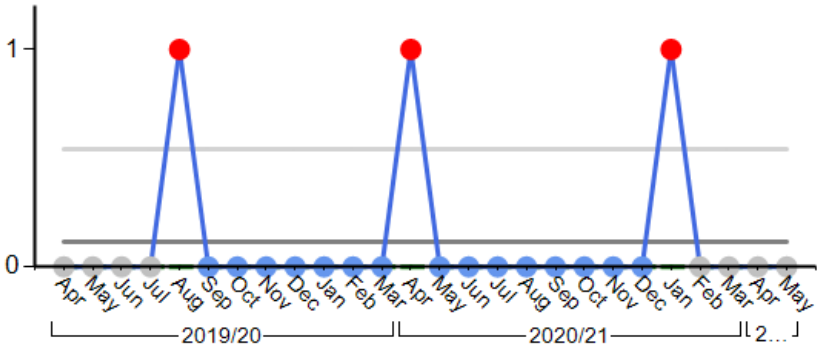
Two E-Coli infections were reported, on 11A and 10B, both have been investigated with no lapses in care.

PHE are now reporting bacteraemia's in the same way as C diff, hence the hospital cases not only include Hospital Onset Healthcare Associated (HOHA) cases (infections occurring on the 3rd day or later following admission (when day 1 is the first day the patient presented at the hospital), but also Community Onset Healthcare Associated (COHA) defined as an infection occurring within 28 days of a recent hospital admission.

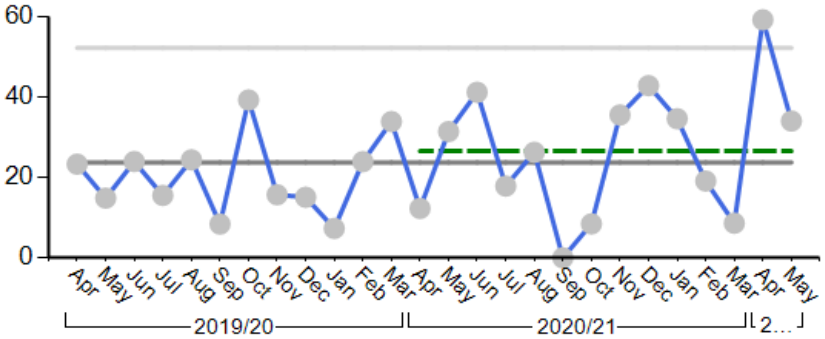
Three MSSA infections were reported; two Hospital Onset Hospital Acquired and one Community Onset Hospital Acquired. Both HOHA cases have been investigated with a delay in obtaining blood culture identified from SSU which may have delayed appropriate antimicrobial treatment. The 2nd MSSA HOHA infection was attributed to ward 11B; this patient received treatment which they responded to, however even after all the appropriate diagnostic tests the source of the infection was not identified and the Consultant Microbiologist considered that this may have been a contaminant. The Community Onset Hospital Acquired was reported originating from ward 7A, with no identified lapses in care.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	May 21		0	0	Apr 21	0	0	
Clostridium Difficile - per 100,000 bed days	26.5	34	4	May 21		26.5	59.1	Apr 21	26.5	46.6	
E. Coli - per 100,000 bed days	20.6	16.4	2	May 21		20.6	25.3	Apr 21	20.6	20.8	
MSSA - per 100,000 bed days	8.8	24.6	3	May 21		8.8	0	Apr 21	8.8	12.5	

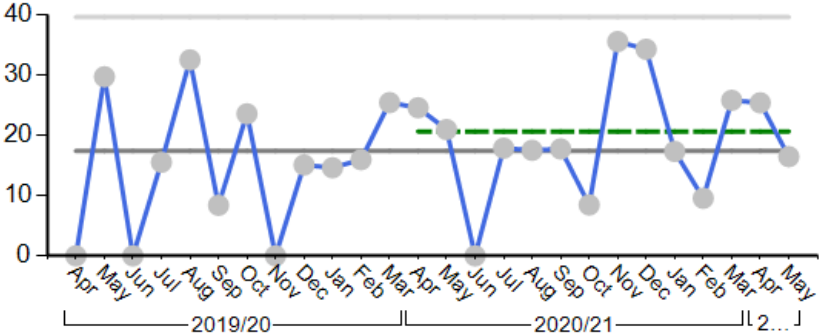
MRSA



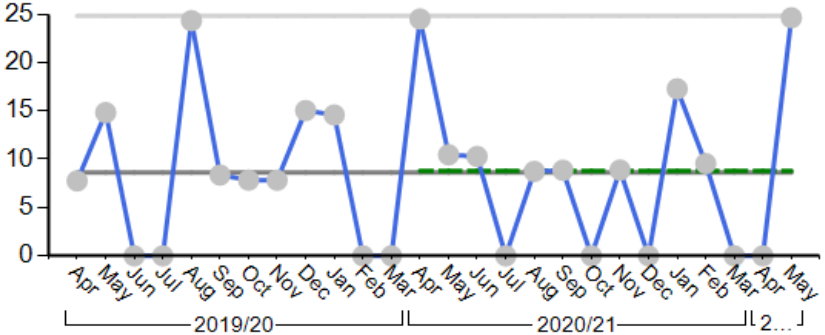
Clostridium Difficile - per 100,000 bed days



E. Coli - per 100,000 bed days



MSSA - per 100,000 bed days



Quality

Maternity

Analyst Narrative:

No indicators within this section are assured, but equally none are failing assurance, with intermittent performance. The caesarean rate continues to show special cause concern but there has been a significant decrease in May to expected levels. Although not statistically significant, the induction rate has risen in May, to its highest level since August 2019. The stillbirth rate and the Maternity Complaints are both showing special cause concern due to the spikes in March. Additionally, the Neonatal Mortality rate is showing special cause concern with 1 reported in May.

Operational Narrative:

Caesarean Sections
The caesarean section rate has decreased in month (30.6%) and is a 3.2% improvement on the year-to-date position. Caesarean section rates have been notably increasing across Cheshire and Merseyside.

Induction of Labour
Induction of labour rates remain above target. Audits are being completed by Consultant Obstetricians and Consultant Midwife with a plan in place to report to Trust Board quarterly on findings and outcomes.

Maternity Complaints as % of Deliveries
There were two new complaints in May 2021:
-one complaints related to care post c-section.
-one patient unhappy with care received in Delivery Suite and Paediatrics.

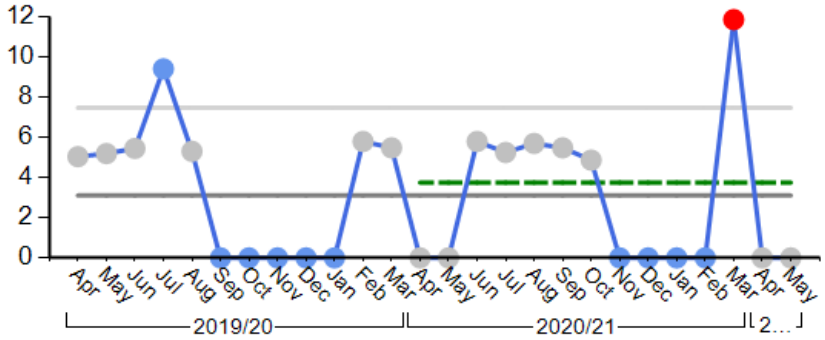
Breastfeeding Initiative
62.6% - been above target over the last 3 months although reduced this month. It is expected that this will improve next month.

3rd and 4th Degree Tears
3rd and 4th degree tears from unassisted births increased in month (4 patients) cases reviewed and care appropriate
3rd and 4th degree tears from assisted births improved on plan. Plan 11% year to date 6.5%

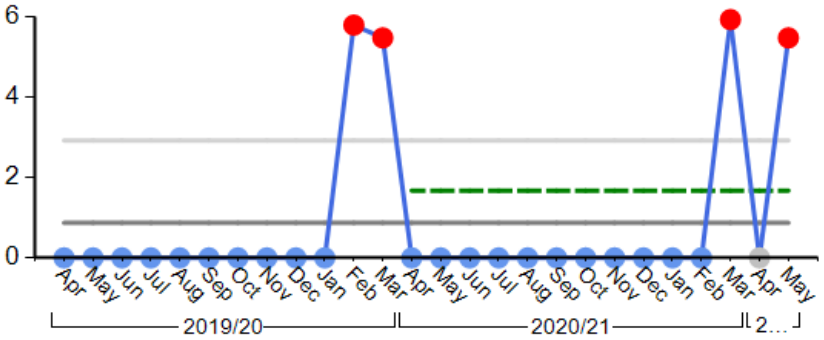
Neonatal Deaths
There were no neonatal deaths in April or May 2021 in the Trust. However, there was a neonatal death in May reported by another Trust (Neonatal death investigation process including HSIB and PMRT being completed jointly).

	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	May 21		3.7	0	Apr 21	3.74	0	
Neonatal Mortality Rate (per 1,000 births)	1.67	5.5	1	May 21		1.7	0	Apr 21	1.67	2.9	
Number of Maternal Deaths	0	0	0	May 21		0	0	Apr 21	0	0	
Caesarean Rates	28.5%	30.6%	56	May 21		28.5%	37.3%	Apr 21	28.5%	33.8%	
Induction Rate	38%	49.2%	90	May 21		38%	48.2%	Apr 21	38%	48.7%	
Breastfeeding Initiation	62%	62.6%	67	May 21		62%	65.8%	Apr 21	62%	64.1%	
Percentage of Women Booked by 12 weeks 6 days	90%	88.2%	26	May 21		90%	93%	Apr 21	90%	90.5%	
Number of Occasions 1:1 Care Not Provided	0	0	0	May 21		0	0	Apr 21	0	0	
Maternity Complaints as % of Deliveries	0.7%	1.1%	2	May 21		0.7%	0.6%	Apr 21	0.7%	0.9%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	3.9%	4	May 21		1.5%	0.7%	Apr 21	1.5%	2%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	4.2%	1	May 21		11%	9.1%	Apr 21	11%	6.5%	

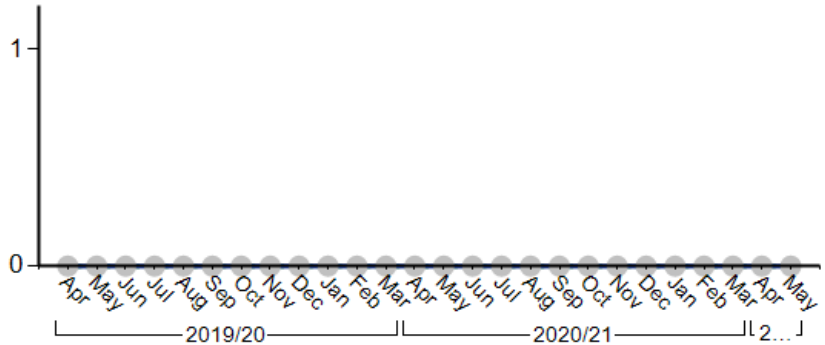
Stillbirth Rate (per 1,000 births)



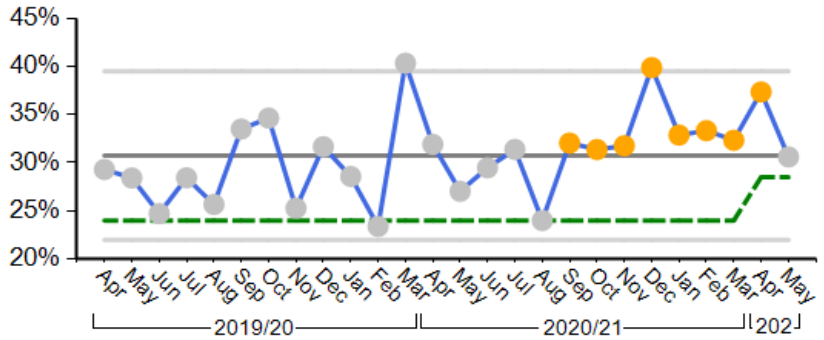
Neonatal Mortality Rate (per 1,000 births)



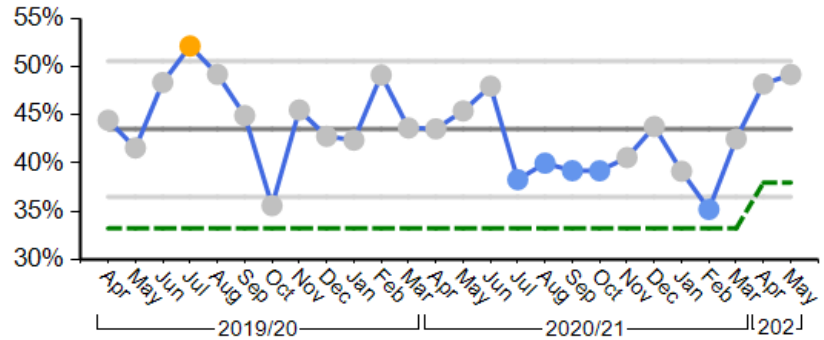
Number of Maternal Deaths



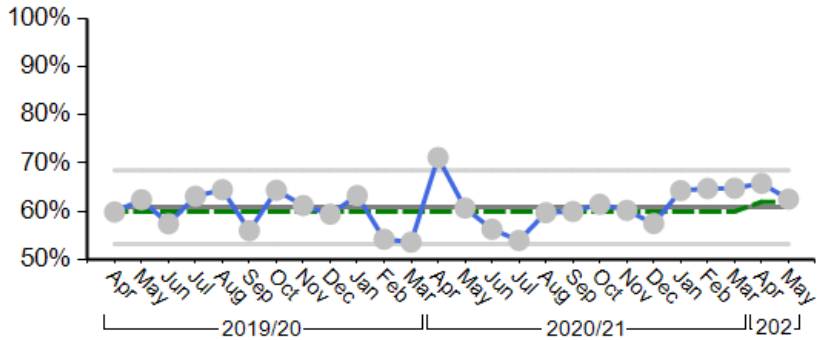
Caesarean Rates



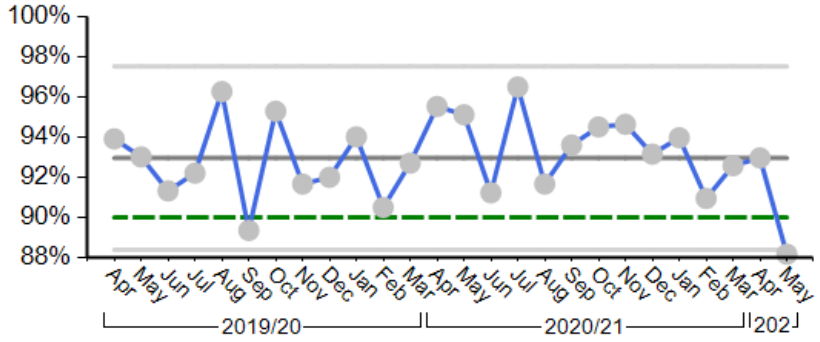
Induction Rate



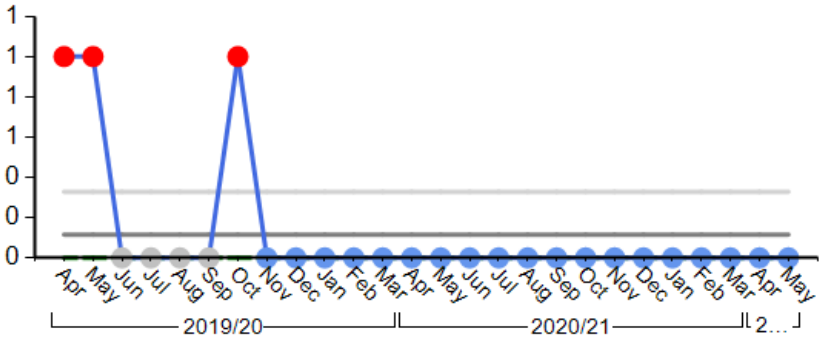
Breastfeeding Initiation



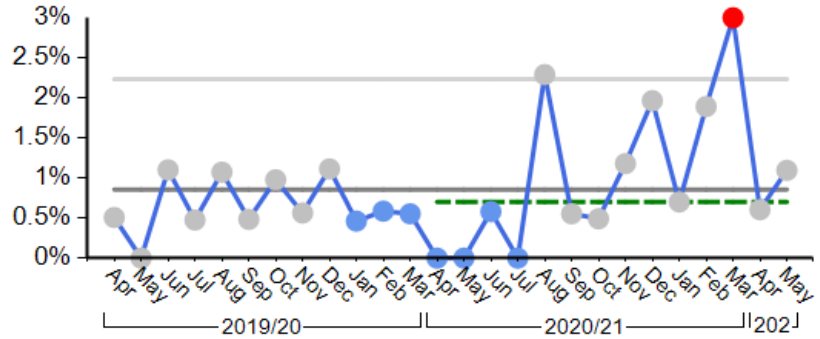
Percentage of Women Booked by 12 weeks 6 days



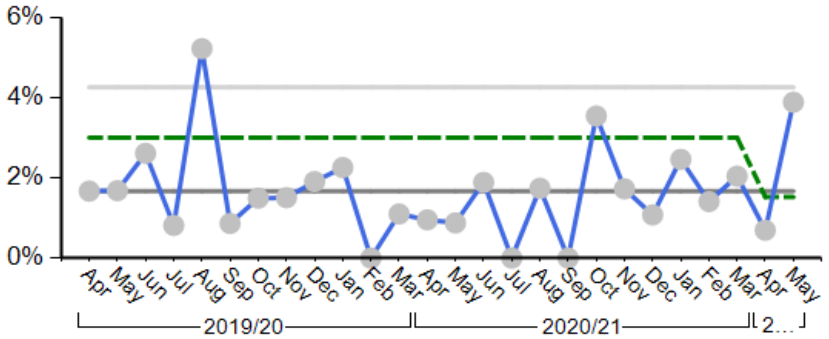
Number of Occasions 1:1 Care Not Provided



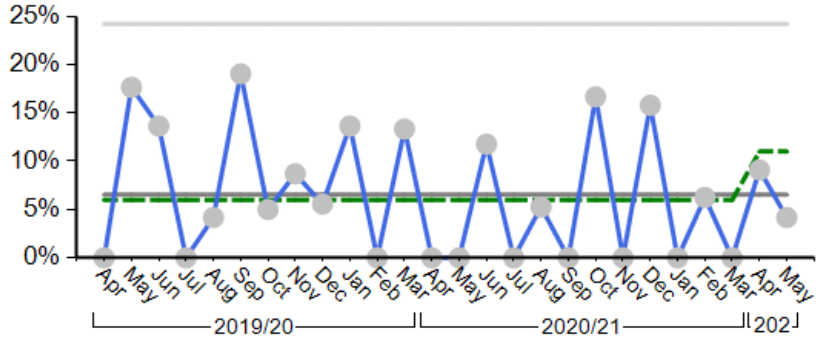
Maternity Complaints as % of Deliveries



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



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



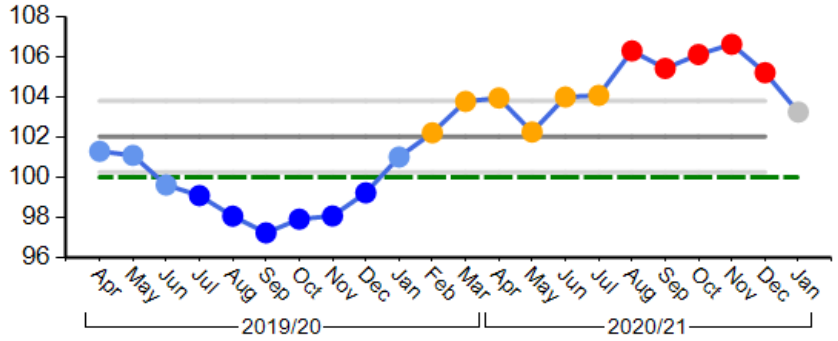
Quality

Mortality

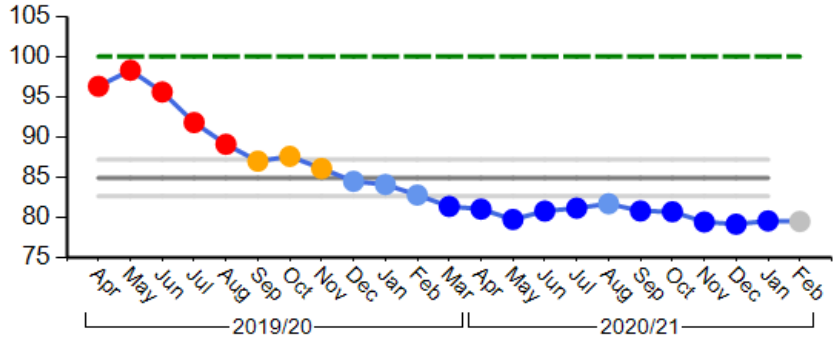
The latest SHMI, for the 12 month period ending December 2020 is 105.2. The HES forecast is predicting Trust SHMI will remain at this level, with marginal fluctuations, for at least the next 2 periods. In the 12 month period ending December 2020 there are 3.7% of spells (1,165 spells) excluded from mortality reporting due to Covid. This is expected to increase significantly in the next months as we incorporate the second Covid wave.
The HSMR continues to be assured and show positive variation. Additionally, this month there are no local diagnosis groups being reported with an SMR greater than 100. The mortality screening rate (15.52%) is the same as last month but still far below the required rate. This is will improve with the Medical Examiner's Officer in post.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	103.2	N/A	Jan 21		100	105.2	Dec 20	100	104.7	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	79.5	N/A	Feb 21		100	79.6	Jan 21	100	79.5	?
Percentage of Deaths Screened	100%	15.5%	49	Apr 21	L	100%	15%	Mar 21	100%	15.5%	F
Perinatal Mortality Rate	5.4	5.5	5.46	May 21	H	5.4	0	Apr 21	5.4	2.7	?

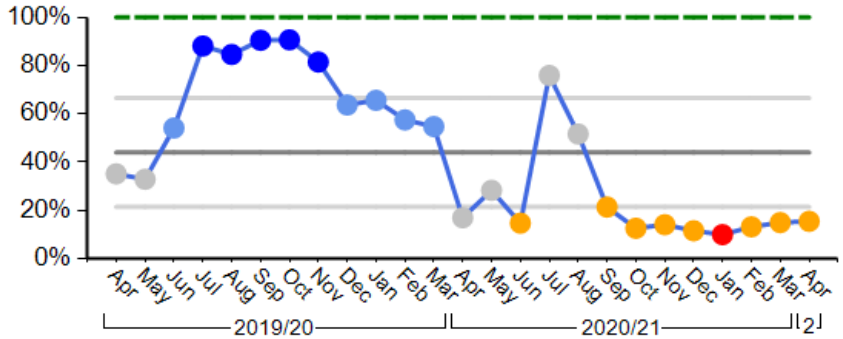
SHMI (Summary Hospital-level Mortality Indicator)



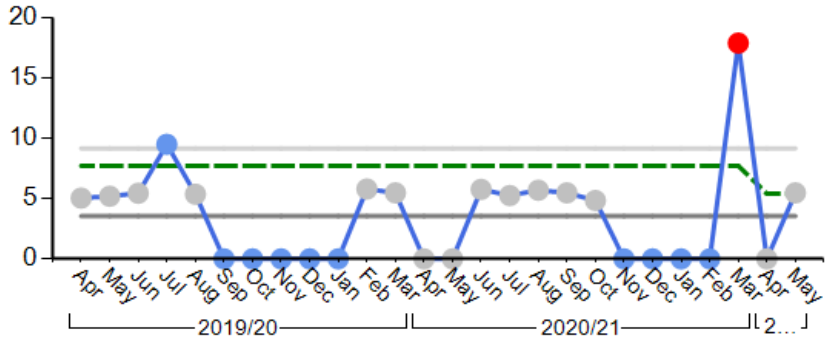
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Perinatal Mortality Rate



Quality

Patient Experience

Analyst Narrative:

The only indicator failing its assurance measure is Delivering Same Sex Accommodation (DSSA). This is however due to historical performance with the indicator showing recent positive variation. The target for written complaints has been revised based on a stretch 10% reduction on the numbers received in 2019/20. Whilst the Trust has exceeded this in May, performance remains within expected levels. Whilst not statistically significant, performance on the complaints responses has deteriorated in May and is below the mean. This requires further narrative. The Patient Friends and Family Test - % that Would Recommend has continued on a downward trajectory since February and has breached the 3rd lower control limit. An action plan has been included in relation to this. Both Duty of Candour indicators continue to show special cause improvement with 100% achieved in May.

Operational Narrative:

There has been an increase in the number of complaints received, from 12 to 25. The increase has primarily been driven from Urgent Care, whose complaints have increased from 10 to 17. These complaints are discussed at the Matron's Meetings and weekly Complaints Review meeting. Themes have been identified relating to communication, predominantly alongside fundamental care/condition on discharge. Additionally, Planned Care have had a notable increase from 0 complaints received in April to five in May, with two originating from Coroner's enquiries.

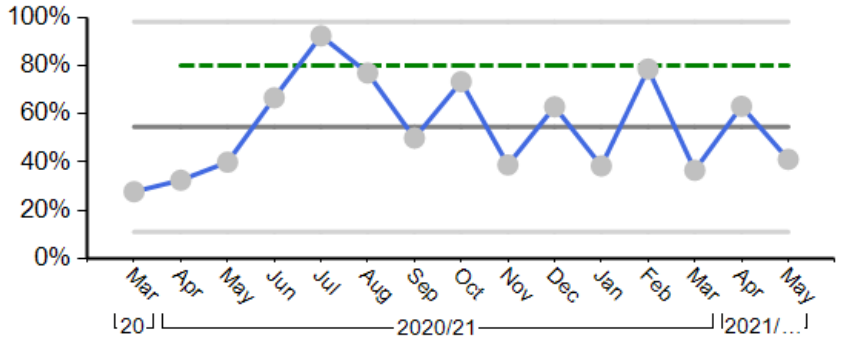
Whilst not statistically significant, there has been a decrease in the proportion of complaints closed within 40 working days. There will be a continued and increased focus on this KPI which has been impacted by the complexity of complaints and capacity within the team, in addition to increased activity at both A&E's in May. The position is expected to improve in June.

There have been 3 reported breaches of Delivering Same Sex Accommodation in month, all delayed discharges from Critical Care with each case being highlighted at the 3 x Daily bed meeting.

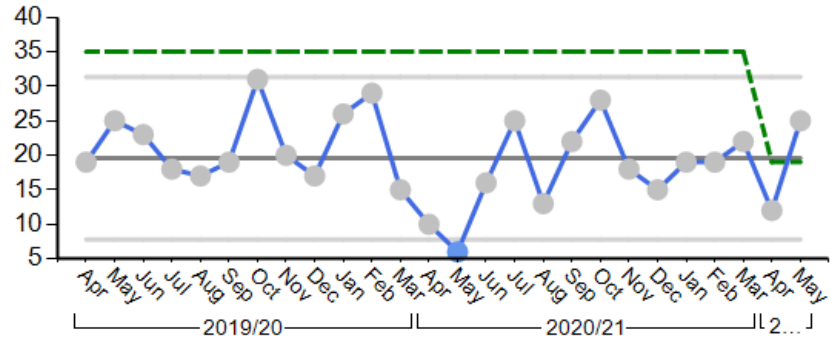
An action plan has been developed to address the deterioration in performance against the Friends and Family - % that Would Recommend indicator. This is included within the IPR.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	41.2%	N/A	May 21		80%	63.2%	Apr 21	80%	52.8%	
Written Complaints	19	25	25	May 21		20	12	Apr 21	233	37	
Friends and Family Test - Patients - % Response Rate	15%	23.8%	5990	May 21	H	15%	25%	Apr 21	15%		
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	89%	207	May 21	L	94%	89.8%	Apr 21	94%	89.4%	
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall	83%	NTR	N/A	May 21		83%	NTR	Apr 21	83%	58.4%	
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	3	3	May 21	L	0	4	Apr 21	0	7	F
Duty of Candour - Evidence of Discussion	100%	100%	0	May 21	H	100%	100%	Apr 21	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	May 21	H	100%	100%	Apr 21	100%	100%	

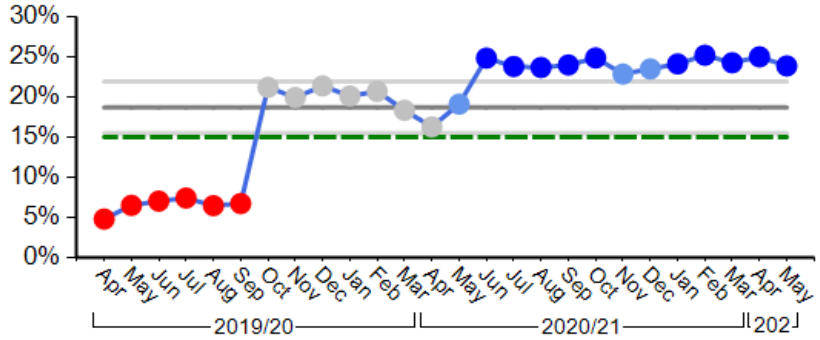
Complaints - % closed within 40 working days



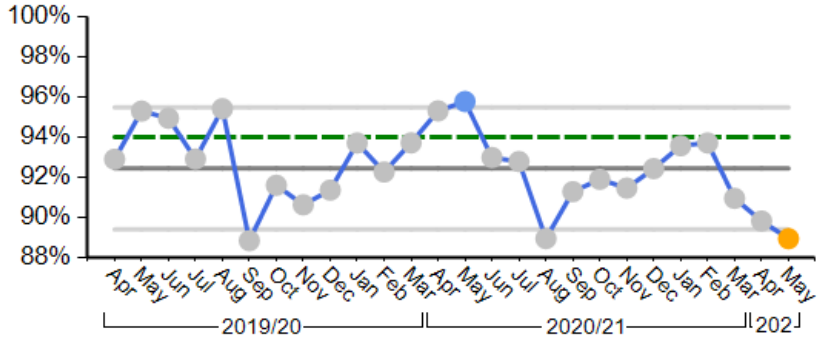
Written Complaints



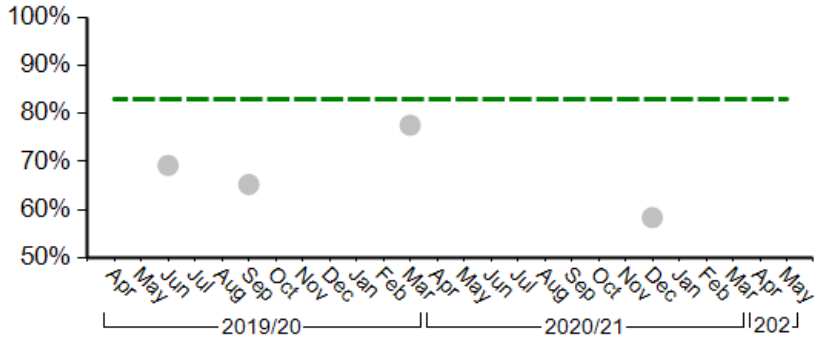
Friends and Family Test - Patients - % Response Rate



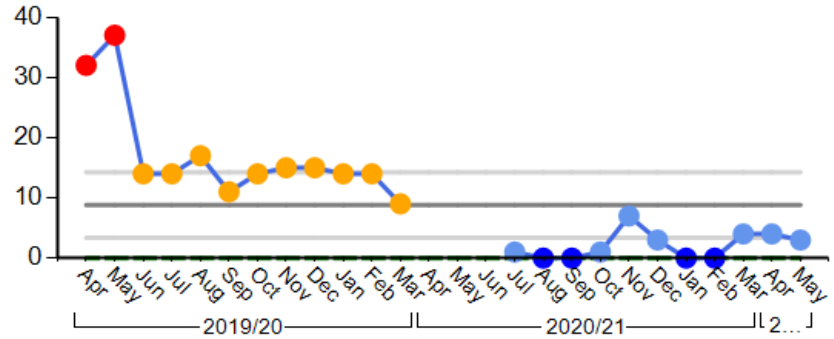
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



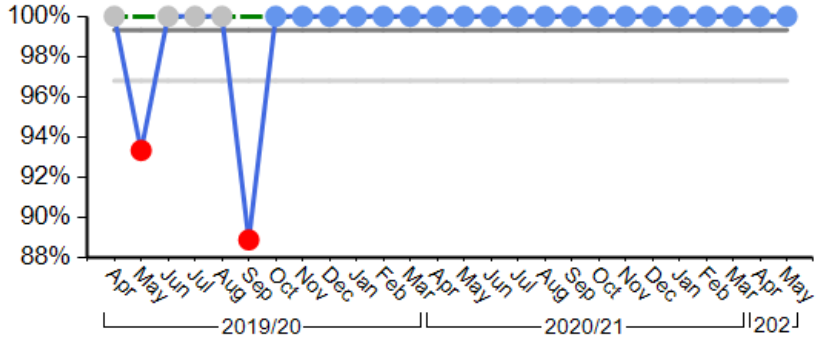
Friends and Family Test - Staff - % That Would Recommend For Care/Treatment - Trust Overall



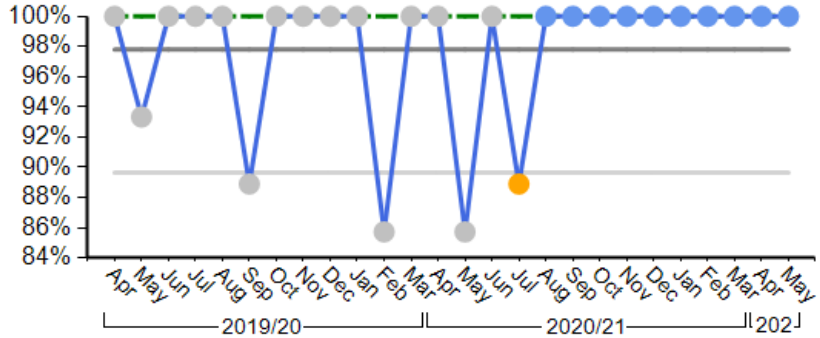
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



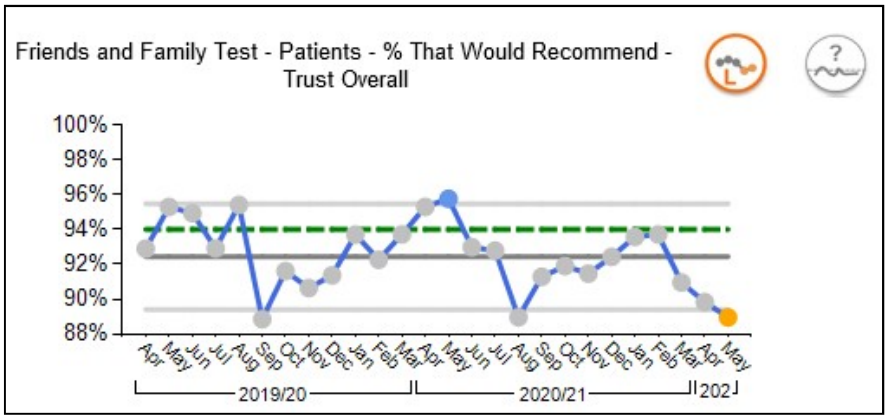
Duty of Candour - Evidence of Letter



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

Southport and Ormskirk Hospital NHS Trust

Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	89%	207	May 21	L	94%	89.8%	Apr 21	94%	89.4%	?



Background: The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This indicator is based on those patients who respond that the service was 'Good' or 'Very Good'.

Situation: The indicator has been on a downward trajectory since February 2021. It is now showing special cause concern with performance below the 3rd lower control limit in May. This is against a response rate of 23.8% for May.

Issues:

Decreases in those who rated the service as 'Good' or 'Very Good' in all areas in May.

Themes identified include waiting times, poor communication, clinical treatment, discharge, staff attitude, lack of dignity, cleanliness, food and lost property.

Due to IPC restrictions, the postcard method of collection of the Friends and Family Test was suspended. The use of text messages alone may impact some patient groups.

Actions:

Urgent Care have identified wards which require focus to improve both their response rate and the percentage that would recommend. These areas have focussed action plans in place with support from the ADON.

Within the Spinal Unit the Patient Forum is now supported by A locum Psychologist as well as the Matron. The Matron is also triangulating the feedback that patients give her at the meeting with those of the perceptions of the staff and how they, as a team can improve the overall patient experience. Catering also attend the meeting to support those patients who are in long term to enhance their dietary requirements and make the food more interesting for long term patients.

Within the Women & Children's CBU, a questionnaire has been developed to support the Quality Priorities and obtain real time feedback from patients.

Discussions around resurrecting the postcard method of collecting FFT data are underway.

A Patient Experience conference is being held in June 2021 with representatives from patient groups.

Mitigations:

The annual Patient Experience report will be presented to Quality & Safety Committee in June.

The ADONs will present at the Patient Experience and Engagement forum regarding FFT and areas of focus.

The Trust Patient Experience lead is due to return to the Trust in August 2021.

FFT Response Rate and Recommendation rate addressed through PIDA.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB118/21**	**FOI Exempt**	**NO**
Report Title	**SUMMARY REPORT OF CHANGES TO INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Andrew Chalmers, Consultant Nurse/Deputy Director - Infection Prevention & Control		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The IPC BAF was first reported to the Board in July 2020 and is now presented to Quality & Safety Committee and Board on a monthly basis.

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

Progress

The area that has moved to BLUE following improvements includes:

- The clinical waste cupboards now being completed and stock of tiger waste bags now being available to allow appropriate segregation of waste

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

1. Hand Hygiene Audits - Trust compliance May 2021 **(95.3%)** ↓ above target
2. PPE Compliance Audits - Trust compliance May 2021 **(95.2%)** ↑ above target
3. IPC Mandatory Training - Compliance –
    a. Level 1Apr 2021 **(92.12%)** ↑ above target
    b. Level 2 training Apr 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

• Consistency of staff allocation & restricted movement of staff between different areas – we are minimising staff movement between areas, however due to current vacancies this isn't always possible.
Recommendations
The Board of Directors are 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 (May 21)	New BRAG Rating (June 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 (May 21)	New BRAG Rating (June 21)
	• LAMP kits and instructions distributed to all departments and secure drop off bins situated throughout the hospital				

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 adhoc 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 (May 21)	New BRAG Rating (June 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 (May 21)	New BRAG Rating (June 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%)	None	None		

	• 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.				

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 (May 21)	New BRAG Rating (June 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	I			

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 (May 21)	New BRAG Rating (June 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%)**.	None	None		

	• 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 respiratorIPC 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 (May 21)**	**New BRAG Rating (June 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 (May 21)	New BRAG Rating (June 21)
• **restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff**	• COVID-19 pathways in place. On admission patients are assigned to a covid zone (red, amber green). Green areas are on the Ormskirk site, amber areas are paediatrics, maternity and emergency surgery and medicine wards. Red areas are wards with covid positive or strongly suspected patients primarily on the Southport site. • Staff are assigned individual wards and on the whole are kept within that ward unless there are extenuating circumstances	None	N/A		

	• 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 (May 21)	New BRAG Rating (June 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. • Capital scheme to upgrade waste storge areas have now completed and supply of tiger bags received.	None	N/A		

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 (May 21)	New BRAG Rating (June 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 respiratorReported 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 (May 21)	New BRAG Rating (June 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	• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (May 21)	New BRAG Rating (June 21)
pathways, as per national guidance					

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

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB119/21**	**FOI Exempt**	**NO**
Report Title	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY SERVICES INCENTIVE SCHEME REPORT**		
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 update the Board on the progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme 10 safety actions and to advise the Board on their requirements.

Executive Summary

This paper provides an update on compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme. This scheme offers up to 10% rebate of the Maternity premium for Trusts that are able to demonstrate compliance against 10 safety actions.

The maternity incentive scheme was launched in 2017/2018 and is now in its third year. This scheme supports the Safer Maternity Care Ambition by supporting the delivery of safer maternity care by rewarding Trusts that meet ten safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services. Due to the impact of Covid-19 the scheme was temporarily put on hold and was relaunched on 01 October 2020 with a deadline for submission of achieving the 10 safety actions by the 20 May 2021. However due to Covid-19 the guidance has been updated again in January 2021 and then again in March 2021 with amendments to the standards with the deadline for submission now 15 July 2021. The implementation plan outlines the Trust's current level of compliance. The plan outlines current status as well as intervention required to progress to compliance as follows:

9 Safety Actions are 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 3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into the Neonatal Units programme?	Compliant
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Compliant
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?	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

Safety Actions 4 Partial compliance

Safety Action 4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?** Neonatal nursing and medical workforce requirements are not fully compliant with the safety action. **Action required by Board** : If this is not met, an action plan to address deficiencies is required and agreed at board level. (See additional paper presented) The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action.	On track
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?** 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.	Compliant by July 2021

In order to be eligible for payment under the scheme Trusts must submit a completed Board declaration form to NHS Resolution by 12 noon on Thursday 15 July 2021.

The Board declaration form must be signed three times and dated by the Trust Chief Executive to confirm that:

- The Board is satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the Trust's maternity services.
- There are no reports covering either this year (2020/2021) or the previous year (2019/2020) that relate to provision of maternity services that may subsequently provide conflicting information to the declaration (eg CQC, HSIB) All such reports should be brought to attention of the MIS team

Recommendations

Southport and Ormskirk Hospital NHS Trust

The Board is asked to note:

Safety Action 4

- Agree action plan to address deficiencies of the neonatal workforce (See appendix 1)
- The Trust Board is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action.

Safety Action 8

- Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, MDT training when this is permitted.

Requirement for submission

- the requirement to certify the Trust's declaration following consideration of the evidence provided.

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

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 (Revised Safety Actions March 2021)

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 MBRACE 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 identifying death 72 hour review Minutes of SIRG PMRT tool reporting Quarterly reporting to Board Minutes of Board Minutes of Safety Champions meeting

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

			Audit demonstrating compliance
	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 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	**Compliant** Reports completed within timescales	Evidenced by PMRT tool reporting Report completed within timescales Audit demonstrating compliance
	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 Audit demonstrating compliance
	Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed	**Compliant** Quarterly reports presented at Trust Board and Maternity Safety Champions meetings	Quarterly reports on agenda for Trust Quality & Safety Committee and Trust Board

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Date: June 2021

	and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.		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
	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 from LMS that that Trust was compliant 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 was compliant 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)	**Compliant**	Data submitted to MSDS Evidence pulled from NHS Digital

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

	MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby) MSD901 Staff Details		
	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
	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	**Compliant**	Data is not captured on Badgernet but is captured the Maternity Information System To date no requests have

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

	Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		been made for information from ODN or commissioners
	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.	**Compliant** Pathways in place to avoid term admissions to NNU including Jaundice, infection and hypoglycemia which are now embedded. Respiratory pathway in place which is 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?			
	Anesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	**Compliant June 2021** **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	Elective list in place once a week which ceased at onset of COVID and not yet recommenced Expected to recommence in July 2021 Copy of rotas will be available at this time demonstrating compliance

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Date: June 2021

		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** A resident Tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7	Copy of Rotas
		Partially Compliant An immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located paediatrics unit (eg between 0900 – 22.00hrs 7 days per week)	Tier 2 doctor allocated to the NNU during working week. However at weekend long day doctor covers Paediatrics as well The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met an action plan should be developed to meet the recommendations signed off by Trust Board

	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**	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 and 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

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

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 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	**Compliant**	Each element has been implemented with exception of Element 2 Point 2 'in pregnancies identified as high risk at booking uterine artery Doppler flow velocity is performed by 24 completed weeks' This is included in SOP and clinic will be in place by July 2021 performing this procedure
	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	Pathways E Mails shared with CCG's NHS Digital Quarterly Smoking Cessation reports Annual reports

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

		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	
	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) 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 organizsation'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	**Compliant** Growth of the fetus is measured and monitored by manual plotting of measurements during antenatal assessments. However, there are risks of errors associated with manual plotting. GROW is an electronic tool which interfaces with the Maternity Information System to assess fetal growth by using customised growth charts bespoke for each woman. There has been a delay in implementing GROW due to System C upgrading the current Maternity Information System. If not successful manual audit will be needed of 40 cases	SOP for Third Trimester Growth Northwest Fetal Growth Guidelines Audits of GROW Manual audit will be needed of 40 cases Element 2 Point 2 'in pregnancies identified as high risk at booking uterine artery Doppler flow velocity is performed by 24 completed weeks' This is included in SOP and clinic will be in place by July 2021 performing this procedure

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

	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		
	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 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%.	**Compliant**	Pregnancy Booking Information pack Mid Pregnancy Information pack Audits of reduced fetal movements demonstrating compliance

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Date: June 2021

	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 speciality 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 demonstrating compliance
	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 and pathways in place Audit of optimizing preterm birth Audit of PRECEPT findings Audit of pre term labour

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Date: June 2021

	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 this is 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.		Audit completed 2020 Repeat audit in progress expected to be completed by end of June 2021
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	**Compliant**	Evidence from chair that they have had remuneration for their services

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	Committee are able to claim out of pocket expenses		
	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?**		
	Covid-19 specific e-learning training has been made available to the multi-professional team members?	**Compliant**	Training database
	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	**Compliant**	Training database
	there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted	**Compliant**	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

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Date: June 2021

	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.	**Compliant**	During COVID staff briefing sessions held with opportunity for feedback which went through to Gold Command Board safety Champion walkabouts in place update provided to staff on issues raised at walkabouts and via E Mail Safety Champions 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 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.	**Compliant**	COC action plan CoC SBAR Minutes of Safety Champions meeting Minutes of PIDA Trust Board minutes quarterly
	Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to: 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**	DATIX reporting Patient safety meetings PIDA Metrics
	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

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	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?**		
	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.	Audit demonstrating compliance
	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 Audit demonstrating compliance
	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 Audit demonstrating compliance

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	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

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

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Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB119/21**	**FOI Exempt**	**NO**
Report Title	**NHS RESOLUTION MATERNITY INCENTIVE SCHEME (CNST) – YEAR THREE SBAR - NEONATAL WORKFORCE SAFETY ACTION 4**		
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

Paediatric Services is not compliant with Safety action 4 of the CNST Safety Actions (March 2021) which asks 'Can you demonstrate an effective system of clinical workforce planning?' Where the service cannot demonstrate compliance an action plan is in place and agreed at board level to meet these recommendations. This paper is to provide Board with a SBAR and action plan as required

Executive Summary

This paper provides an update on compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme. This scheme offers up to 10% rebate of the Maternity premium for Trusts that are able to demonstrate compliance against 10 safety actions. We are able to demonstrate compliance with 9 of the Safety Actions with 1 Safety action partially compliant as follows:

Safety Actions 4 Partial compliance

Safety Action 4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?** Neonatal nursing and medical workforce requirements are not fully compliant with the safety action. **Action required by Board** : If this is not met, an action plan to address deficiencies is required and agreed at board level. (See additional paper presented) The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action.	On track

Recommendations

The Board is asked to note:

- Board note the recommendations required to meet Safety Action 4
- Board approve the action plan for the Neonatal Workforce requirement This will meet the requirements for CNST
- Trust Board formally record in the Trust Board minutes that the action plan has been approved

Previously Considered By:

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

Southport and Ormskirk Hospital NHS Trust

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

Southport and Ormskirk Hospital NHS Trust

Specialist Services Clinical Business Unit

NHS Resolution Maternity Incentive Scheme (CNST) – Year Three

SBAR - Neonatal Workforce Safety Action 4

S

Situation

Paediatric Services is not compliant with Safety action 4 of the CNST Safety Actions (March 2021) which asks 'Can you demonstrate an effective system of clinical workforce planning?'

Where the service cannot demonstrate compliance an action plan is in place and agreed at board level to meet these recommendations

B

Background

The maternity incentive scheme was launched in 2017/2018 and is now in its third year.
This scheme supports the Safer Maternity Care Ambition by supporting the delivery of safer maternity care by rewarding Trusts that meet ten safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services.

Safety Action 4 includes four components related to obstetric, anaesthetic and paediatric medical workforce and neonatal nursing workforce.

Whilst there is evidence to support the requirements of three components we are not in a position to demonstrate compliance for the two components related to the Paediatric and nursing workforce for neonatal services.

The requirements for these are as follows:

Neonatal medical workforce

- The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. - an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located paediatrics unit (eg between 0900 – 22.00hrs 7 days per week)

The Current situation is:

- Tier 2 doctor allocated to the Neonatal Unit during working week. However at weekend long day doctor covers Paediatrics as well

Neonatal Nursing Workforce

- The neonatal unit meets the service specification for neonatal nursing standards.

The Current situation is:

There is a gap of 5wte trained nurses

A	**Assessment** **Neonatal Medical Workforce** The requirements for medical staffing have been assessed by the Clinical Director for Paediatrics and to ensure that the Neonatal Unit is covered 7 days per week between the hours of 0900 – 2200hrs three additional middle grade doctors will be required. The gross cost being £209,858 (which includes on-costs NI, Pension etc) on a p/a basis (Costings attached as Appendix 1) The regional Neonatal Network has been contacted for guidance regarding achieving fully these requirements who have advised that there would be an expectation that the service is compliant within the next 12 months **Neonatal Nursing Workforce** A workforce review has been completed based on the staffing guidelines referenced in Safety Action 4. There is a shortfall of 5 wte trained nurses (Band 5). The gross cost being: £275,000 However, the Regional Neonatal Network has made a commitment to funding neonatal nursing posts across the region where these do not meet the recommendations. In May 2021, we were awarded funding of £110,00 for 2.0wte Band 5 trained nurses and there is a further commitment to funding the remaining 3.0wte shortfall over the next 12 months. The Associate Director for Midwifery & Nursing and the Matron for Paediatrics continues to work collaboratively with the Neonatal Network A risk assessment has been completed (attached as Appendix 2) which will be reviewed and signed off at the Paediatric Triumvirate meeting on the 1st July 2021 prior to being put onto DATIX. This describes the risks and mitigations in place **CNST Requirements for Submission by 15th July 2021** If this safety action is not met, an action plan to address deficiencies is required which needs to be agreed at board level. The action plan is attached (as Appendix 3) The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action.
R	**Recommendations** **1.** Board note the recommendations required to meet Safety Action 4 **2.** Board approves the action plan for the Neonatal Workforce requirement only as there are plans in place with the Regional Neonatal Network to fund the nursing shortfall. This will meet the requirements for CNST **3.** Trust Board formally record in the Trust Board minutes that the action plan has been approved

Appendix 1

Middle Grade Doctors (ST3-ST5 - Nodal Point 4)					
	Basic Salary	On Call	Weekend Allowance (1 in 7)	Total	
4 Middle Grade doctors per rotation from Lead Employer	50,017	4,002	1,501	55,520	69,953
4 Middle Grade doctors per rotation from Lead Employer	50,017	4,002	1,501	55,520	69,953
4 Middle Grade doctors per rotation from Lead Employer	50,017	4,002	1,501	55,520	69,953
4 Middle Grade doctors per rotation from Lead Employer	50,017	4,002	1,501	55,520	69,953
Total	200,068	16,008	6,004	222,080	279,811
Farooqi JS - MC4611	66,614	5,330	1,998	73,942	93,567
Gouda NFKM - MC4605	55,790	4,464	1,674	61,928	78,166
Bibi A - MT0401	50,017	4,002	1,501	55,520	69,953
Total	172,421	13,796	5,173	191,390	241,685
additional 3 Middle Grade Doctors to support NNU	50,017	4,002	1,501	55,520	69,953
additional 3 Middle Grade Doctors to support NNU	50,017	4,002	1,501	55,520	69,953
additional 3 Middle Grade Doctors to support NNU	50,017	4,002	1,501	55,520	69,953
Total	150,051	12,006	4,503	166,560	209,858
Sum of total	522,540	41,810	15,680	580,030	731,355

Author: L Eastham, Associate Director of Midwifery/Nursing June 2021

Risk Matrix	
Likelihood	**Severity**
1 - Rare	1- Insignificant
2 - Unlikely	2 - Minor
3 - Possible	3 - Moderate
4 - Likely	4 - Major
5 - Almost Certain	5 - Catastrophic

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Ward/Department – Paediatric Neo-Natal Unit

Appendix 2

Subject of Assessment: Middle Grade Neo-Natal Cover from 0900 - 2200

DRAFT - Assessment Date: 30/06/2021

Review Date: TBC

Strategic Domain	Organisational Imperative	RISK/HAZARD	Severity (s) & Likelihood (l) (refer to risk matrix)	Level of Risk (R) (without controls/actions)	Actions/controls previously taken to reduce risk	Level of Risk (R1) (With Control/actions)	Additional measures that would reduce risk.	Person Responsible	Date Completed
		The Neonatal service does not meet the recommendations for a 7 day Middle Grade service solely dedicated to the NNU at least during the periods which the unit is at it's busiest between the hours of 0900 -22.00 Middle Grade doctor would cover multiple areas on different floors.			A Middle Grade is doctor allocated to the NNU during Monday – Friday 0900-1700 Saturday & Sunday 1900-2100 there is Consultant resident support to ensure the Registrar can attend Neonatal emergencies promptly		The on-call consultants cover resident Monday to Friday 17:00 to 20:00. Outside the hours of 1900 – 2100 the on-call Consultant can be called		

Author: L Eastham, Associate Director of Midwifery/Nursing June 2021

Strategic Domain	Organisational Imperative	RISK/HAZARD	Severity (s) & Likelihood (l) (refer to risk matrix)	Level of Risk (R) (without controls/actions)	Actions/controls previously taken to reduce risk	Level of Risk (R1) (With Control/actions)	Additional measures that would reduce risk.	Person Responsible	Date Completed
		This would be significant if 2 emergencies occur at the same time. Weekend long day doctor covers Paediatrics as well as other areas Recruitment: Middle Grade recruitment could prove a difficult and lengthy process particularly if doctors from overseas apply. Financial Impact has been identified and assessed resulting in a potential significant cost pressure Shortfall in nurse staffing identified as per BAPM guidelines.			This risk has been lowered since we have resident consultant shifts after 5 pm. Recruitment has already begun to cover the current gaps on the Middle Grade rota. Costs will increase by £210K subject to business case approval Workforce review completed both by the Neonatal Network		to support Neonatal emergencies Statement of case to be formulated and taken through Governance followed by submission of business case including costings in respect of recruitment. Statement of case to be formulated		

Strategic Domain	Organisational Imperative	RISK/HAZARD	Severity (s) & Likelihood (l) (refer to risk matrix)	Level of Risk (R) (without controls/actions)	Actions/controls previously taken to reduce risk	Level of Risk (R1) (With Control/actions)	Additional measures that would reduce risk.	Person Responsible	Date Completed
					and the Trust in February / March 2021. Retrospective data to be analysed to ascertain compliance to the standards and whether re introduction of a Bank budget would be sufficient to maintain standards in the interim.		and taken through Governance followed by submission of business case including costings. If required, additional staff to be utilised through NHSP to maintain standards.		

Completed by: Graeme Seddon & Dr Shyam Mariguddi Date 30/06/2021

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 – Neonatal Clinical Workforce Planning to Required Standard – CNST Safety Action 4 (Revised Standards March 2021)

	Safety Action 4.	Current Status/action in place	Action required to mitigate and resolve issues	Lead	Date for Completion	Completed/ Progress
1.	The neonatal service does not meet with recommendation for an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located paediatrics unit (eg between 0900 – 22.00hrs 7 days per week)	Tier 2 doctor allocated to the NNU during working week. However at weekend long day doctor covers Paediatrics as well	1. Review Middle Grade Rota and feasibility of cover as per recommendations and the number of doctors required to make this possible.	Clinical Director for Paediatrics	June 2021	**Complete**

Author: L Eastham, Associate Director of Midwifery/Nursing June 2021

		Mitigating actions in place include: The neonatal unit is covered by a separate neonatal Tier 2 doctor Monday to Friday 0900-1700 The on-call consultants are resident Monday to Friday 17:00 hours - 20:00 hours. Saturday & Sunday 19:00 hours -21:00 hours so there is resident support to ensure the Registrar can attend Neonatal emergencies promptly outside of these times the on-call Consultant can be called to attend to support Neonatal emergencies .	2. Complete a bench marking exercise to understand 'when unit is 'busiest'	Clinical Director for Paediatrics	December 2021	**Not yet started**
			3. Statement of case to be formulated and taken through Governance followed by submission of business case including costings.	Clinical Director for Paediatrics	December 2021	**Not yet started**

2.	Neonatal Workforce review completed both by the Neonatal Network and the Trust in February / March 2021. Shortfall in nurse staffing identified as per BAPM guidelines – 5.0wte	Funding secured of £110,000 to recruit two Band 5 trained nurses Working collaboratively with the regional Neonatal Network with plans to fund additional shortfall	1. If required, additional staff to be utilised through NHSP to maintain standards.	Paediatric / Neonatal Matron	On track 2021	**On track**
			1. Retrospective data to be analysed to ascertain compliance to the standards and whether re introduction of a Bank budget would be sufficient to maintain standards in the interim.	Paediatric / Neonatal Matron	September 2021	**Not Yet Started**

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Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB120/21**	**FOI Exempt**	**NO**
Report Title	**CQC PROGRESS REPORT**		
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 progress against the action plan following the recent CQC inspection and other engagement with CQC.

Executive Summary

The report provides an update on the Care Quality Commission (CQC) action plan following the unannounced focussed inspection at the Trust on 03 March 2021.

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

The seven 'should do' recommendations have been reviewed and actions identified to demonstrate continuing improvement. In addition, there have been 10 actions completed in the Medicine division following positive external assurance as part of the inspection.

A date is being sought for a quality assurance panel to finalise updates on all actions.

Recommendations

The Board of Directors are asked to note current position of the action plan.

Previously Considered By:

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

Strategic Objectives

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

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

Care Quality Commission (CQC) Update – June 2021

1. BACKGROUND

The Care Quality Commission (CQC) carried out an inspection at the Trust between 10 July 2019 and 01 August 2019 and a well-led inspection between 20 and 22 August 2019. The subsequent inspection report was published on 29 November 2019 where the Trust received a rating of Requires Improvement (RI).

An improvement plan was developed following the outcome of the inspection and progress has been monitored at Quality and Safety Committee and Trust Board.

CQC carried out and unannounced responsive inspection at the Trust on 03 March 2021 and CQC published the inspection report on 13 May 2021. A copy of the full report was provided to the Board at the last meeting.

There were no breaches of regulation identified. However, there were 7 actions the CQC recommend the Trust should take.

This report provides an update on progress against the action plan following the 2019 inspection and additional 'should do' recommendations following the inspection in March 2021.

2. OVERVIEW OF INSPECTION FINDINGS

During this inspection, the Trust was inspected but not rated. The unannounced focused inspection was undertaken following information of concern received from the public.

The inspection was focussed on the Medical Care core service which includes medical wards and departments.

The inspectors noted in the report that:

- Patients are treated with compassion and kindness and their privacy and dignity is respected, and takes account of their individual needs
- Safety incidents are investigated and any resulting actions are implemented and monitored, and lessons learned are appropriately shared
- Staff say they feel respected, supported and valued and can raise concerns without fear
- Leaders have the skills and abilities to run the service, and patients and staff think they are approachable
- A small number of instances had been identified where a family had not been involved in meaningful conversation about their relative's care and treatment, however a recent audit demonstrated improvements in this area
- Assessments around the risks of patients falling have improved since the last inspection and staff identify and act upon patients at risk from their health further deteriorating, however staff don't always update risk assessments for each patient
- The service does not always have enough substantive medical staff, although locum and bank staff and new roles have been created to keep patients safe until long-term recruitment can be resolved

- Consultants lead daily ward rounds and are on site at weekends, with on-call consultants available during out of hours periods - an improvement in cover since the last inspection
- Nursing, medical, and other health professionals were found to keep separate patient records, but it was noted the Trust is continuing towards implementing electronic patient records to support record-keeping
- Patients have enough food and drink to meet their needs and improve their health, however inspectors found staff don't always complete patient fluid charts, although this has improved from the last inspection
- Staff provide emotional support and understand patients' personal needs and had provided contact with families and carers while visiting had ceased during the pandemic
- Complaints are treated seriously, patients are included in the investigation of their complaint, and lessons are shared with all staff

Outstanding practice

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 Covid-19.

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

In the report, CQC identified seven areas for improvement where they identified the Trust 'should' take action. An overview is presented below of the actions against those areas and how they will be monitored (**in Green**).

The Trust should continue to improve the review of patient risk assessments. **This programme of work will be taken forward as part of the Trust quality priority programmes for 2021-22.**
The Trust should continue to improve the involvement of patients and their families in decisions regarding care and treatment where DNACPR (Do not attempt Cardiopulmonary Resuscitation) is considered. **The Trust will continue the improvement work through 2021-22 via the Resuscitation Committee which demonstrated an improvement in DNACPR decision-making in January 2021.**
The Trust should continue towards electronic patient records to promote accuracy of holistic record keeping. **The Trust has revised and implemented its Digital Strategy and has introduced an integrated communication platform for any web device to promote delivering faster clinical communication, improved governance, better collaboration and safer care.**
The Trust should continue to improve discharge arrangements to ensure safe patient discharge.

The Trust has initiated quality improvement events on safer discharge of patients during Q4 developing a revised discharge checklist, improved communication with provider stakeholders and patients; quality discharge forums with providers and follow up welfare checks of patients after discharge.
The Trust should continue to act to address the high number of registered and unregistered nursing vacancies. **By the end of 2020/21, we have achieved the most improved vacancy rate for registered and non-registered nursing and midwifery staffing roles for several years. The international nurse recruitment work has supported this, and we are on track to realise 92 nurses by the end of June 2021. However, we recognise the Covid-19 pandemic has led to some delays.**
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. **This action has been carried forward as one of the quality priorities programme of work for 2020-21.**
The Trust should continue to address the number of medical staffing vacancies across the medical care service. **During 2020-21 we have significantly reduced the number of medical vacancies, starting with 59, and ending the year with 27. Whilst this is a significant achievement, we need to ensure that we maintain the focus on filling these vacancies and are working a number of methods to generate applicants. This has involved working with partner organisations to generate joint posts with academic elements, extending the number of recruitment agencies we work with to source candidates for our difficult to fill roles and exploring how we can offer development opportunities to develop the talent within the organisation for the future.**

3. PROGRESS AGAINST OVERARCHING ACTION PLAN

As a result of the inspection, we have reviewed the full report and current position alongside the 2019 action plan to recognise some of the positive external assurances following this inspection.

Seven new actions have been added as a result of the recent CQC inspection and actions are being taken as shown above. A status update is provided below subject to validation at the Quality Assurance Panel.

A date is being sought for a quality assurance panel to finalise updates on all actions and get a full update on all other actions.

	April 2021			May 2021			Change
Rating	**Must Do**	**Should Do**	**Total**	**Must Do**	**Should Do**	**Total**	
Completed	6	48	54	11	53	64	+10
Progressing on schedule	24	41	65	19	43	62	-3
Slightly delayed and/or of low risk	1	3	4	1	3	4	
Significantly delayed and/or of high risk	0	0	0	0	0	0	
TOTAL	**31**	**92**	**123**	**31**	**99**	**130**	**+7**

4. CQC ENGAGEMENT

We continue to have regular engagement meetings with the CQC via MS Teams and we recently met with CQC on 10 June 2021. At the meeting we discussed:

- Update on Trust recovery and restoration plans
- 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

5. RECOMMENDATIONS

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

6. REFERENCES

CQC Inspection Report – Southport and Ormskirk Hospital NHS Trust – Southport and Formby District General Hospital – Medical Care (including Older People's Care). Published 13/05/2021

https://api.cqc.org.uk/public/v1/reports/e9ed1194-4dbc-4aa3-ab85-1c640e1b6d9e?20210513010517

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB121/21**	**FOI Exempt**	**NO**
Report Title	**UPDATE ON ORTHOPAEDICS SERVICE**		
Executive Lead	Dr Kate Clark, Medical Director		
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 Orthopaedic Royal College review

Executive Summary

In late 2019 the Trust was made aware via NHS Resolution (NHSR), our 'insurers', of a possible group action with respect to primary hip replacements, that had failed prematurely and needed revision. Following an internal review of 58 cases of revision hip replacement, 29 cases warranted further scrutiny. The previous Medical Director commissioned an external review of those cases from the Royal College of Surgeons. The review has been received and identified 9 cases which "indicated that a technical error during the arthroplasty surgery likely contributed to premature failure of the hip replacement". All patients have been contacted in line with the requirements of duty of candour and clinical follow up review offered. The review made 9 recommendations, 4 of which relate to the governance in trauma and orthopaedics. All 9 recommendations are being implemented. A review of the governance has been undertaken and actions are being implemented to address the concerns raised.
It's recommended that the Board of Directors note the outcome of the Royal College of Surgeons review and that steps are being taken to support patients following the outcome of the review

Recommendations

The Board is asked to **note** the actions being taken to address the concerns raised in relation to the governance in Trauma and Orthopaedics, which will be subject to further review for assurance post-implementation.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Dr Kate Clark, Medical Director	Dr Kate Clark, Medical Director

Orthopaedic Review Update - June 2021

1. Introduction

In late 2019 the Trust was made aware via NHS Resolution (NHSR), our 'insurers', of a possible group action with respect to poorly performed primary hip replacements, that had failed prematurely and needed revision.

The National Joint Registry (NJR) also gave notification that we were an outlier for our hip and knee revision rates. As a result, 58 cases of revision hip arthroplasty were reviewed and identified potential concerns in relation to one practitioner who left the Trust in 2017.

On the 14 February 2020 the previous Medical Director (MD) commissioned the Royal College of Surgeons (RCS) to undertake an invited clinical record review of 29 cases of primary hip replacement, performed by that one surgeon.

The MD wrote to all the patients where duty of candour was considered to apply (9) at the time, informing them of the process.

A report was received from the Royal College of Surgeons on the 01 December 2020 and its findings noted. However, data inaccuracies required the findings to be reviewed. The updated and 'final' version was received by the Trust on the 18 March 2021.

A full copy of the report (patient specific info redacted) is provided at Appendix A.

2. Findings from the review

The RCS noted in their review that they were unable to draw conclusions in 7 of the 29 cases due to incomplete records. In the main, this is due to the ongoing care of patients being undertaken at another Trust.

Of the 22 remaining cases, the RCS concluded that in 9 cases the review team considered ***'the information provided indicated that a technical error during the arthroplasty surgery likely contributed to premature failure of the hip replacement.''***

The review also made 9 recommendations, all of which have been acted upon, with ongoing actions for some to provide assurance. Of particular concern is the apparent lack of governance at the time, and four of the actions refer to this going forward:

6. The Trust should review the MDT and pathway arrangements for those undergoing arthroplasty revision surgeries to ensure that there is appropriate MDT-input into decision-making for every patient.

7. The Trust should undertake a comprehensive review of its clinical governance processes relating to orthopaedic surgery in order to ensure that it can monitor performance more robustly and detect any issues as early as possible. The clinical governance structure needs to be robust and adhered to so that issues are escalated through appropriate channels.

8. As part of the review outlined in recommendation 7, the Trust should consider how NJR data is used to monitor performance and drive improvement. It is recommended that their NJR surgeon-level reports are presented in a peer forum annually.

9. The Trust should also ensure the review of NJR surgeon-level reports are included as part of annual appraisal and that any concerns regarding unexpected or negative trends with this data should be discussed with the relevant surgeon(s). One model the Trust may wish to consider is that the arthroplasty team discuss openly each contributing surgeons report in detail in sheltered time, and the conclusions for each surgeon is included in their appraisal. This will cover those eventualities where the appraiser is not an arthroplasty surgeon (or indeed is from a different speciality).

3. Duty of Candour

Initial duty of candour was undertaken with 9 patients (Recommendation 1) as indicated and each patient has been contacted to confirm the outcome of the review.

In addition, letters were issued by the previous Medical Director to patients that were part of the review to ensure they are aware a review has been undertaken, offer a discussion about the findings of the report and a follow up examination at the Trust, if required.

Patients have begun to make contact with the Trust and are being supported with appointments and clinical review where necessary.

We have liaised with NHSR and Hill Dickinson in relation to 'claims' and are supporting their requirements with any cases under review.

4. Fitness to practice (FTP) issues

The practitioner whose cases were subject to the RCS review, 'Practitioner A', was employed from October 2007 but no longer works for the organisation having left in March 2017. The surgeon, their current employer and responsible officer have been provided with a copy of the report along with the GMC via the employer liaison adviser. We have received information to confirm that this has been received and appropriate steps have/are being progressed (Recommendations 3 and 4).

5. Current position

The Trust are no longer commissioned to provide revision surgery but the NJR data, which looks at the last 10 years as a comparator shows that we are an outlier for hip revision rates (i.e. hip replacement surgery that then results in the need for revision surgery) on the Ormskirk District General Hospital site.

The National Joint Registry (NJR) have confirmed that no surgeons currently operating at the Trust are considered outliers in respect of their revision rates. The current position reflects historic practice and is expected to improve as data is updated annually, with the Trust's next Annual Clinical Report for the NJR due to be published in October/November 2021.

At the time the review was commissioned, it was reported as a Serious Incident on the Strategic Executive Information System (StEIS). An action plan is in draft to draw together the agreed actions from the review and wider implications of the report.

In relation to the governance elements of the recommendations – a review has been undertaken with the Clinical Director for Trauma and Orthopaedics to look at how the national joint registry (NJR) data and clinical outcome information is used for arthroplasty and how it will be used going forward.

The trauma and orthopaedic team welcomed the recommendations and are implementing the actions as below.

Recommendation	Action	Assurance
1. The Trust should consider the views of the review team, as well as the other information it holds, and on this basis provide further follow-up of any patients for which it considers this to be required. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.	Initial duty of candour was undertaken with 9 patients as indicated and each patient has been contacted to confirm the outcome of the review. The requirements of the duty of candour is being followed in all cases.	Following the outcome of the RCS review, letters were issued by the previous Medical Director to patients that were part of the review to ensure they are aware a review has been undertaken, offer a discussion about the findings of the report and a follow up examination at the Trust, if required. Patients have begun to make contact with the Trust and are being supported with appointments and clinical review where necessary. We have liaised with NHSR and Hill Dickinson in relation to 'claims' and are supporting their requirements with any cases under review.
2. The review team were unable to determine the outcome for a number of the patients. The Trust should review the care of these patients to ensure they are aware of the outcomes and that the Trust has met its ethical and legal obligations, including those outlined in recommendation 1.	The Trust attempted to obtain ongoing care records from other NHS providers where patients continued their care and the Trust are working within the remit of the General Data Protection Regulations (GDPR) and information governance requirements to obtain this information.	Following the outcome of the RCS review, letters were issued by the previous Medical Director to patients that were part of the review to ensure they are aware a review has been undertaken, offer a discussion about the findings of the report and a follow up examination at the Trust, if required. Patients have begun to make contact with the Trust and are being supported with

		appointments and clinical review where necessary.
3. The Trust should consider with whom the conclusions of this report relevant to the operating surgeon should be shared for the purposes of protecting patient safety, including the operating surgeon's responsible officer and any other known places of work, taking into account the Trust's legal responsibilities towards the confidentiality of their patients and staff.	The Trust has shared the report with the surgeon's responsible officer, other appropriate organisations and regulatory bodies.	The report has been received by the relevant organisations for consideration.
4. The Trust should share and discuss the conclusions in this report that relate to the practice of the operating consultant surgeon, with the operating consultant surgeon to allow them the opportunity to reflect on the contents of the report and consider how they can learn from it and develop their practice.	Communicate with, and provide a copy of the report, to the Consultant operating surgeon.	The Consultant operating surgeon no longer works for the Trust. The report has been provided to the Consultant Operating Surgeon and their responsible officer.
5. The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode(s).	Review the records for each patient to determine if any further information is needed. Undertake routine records audits on an audit cycle.	All records have been reviewed for patients who were part of the review to support the necessary conclusions where the RCS were unable to conclude. As identified, where additional records are required from ongoing care episodes, these are being sought in line with GDPR and Information Governance requirements. A records audit is planned for current T&O patients and this will be done routinely on a cyclical basis moving forward.
6. The Trust should review the MDT and pathway arrangements for those undergoing arthroplasty revision surgeries to ensure	The Trust is no longer commissioned to undertake revision surgery and all cases where revision is needed are referred	All cases where revision surgery is required are referred externally with MDT input from the Trust as required.

that there is appropriate MDT-input into decision-making for every patient.	externally. The Trust participates in any MDT with the provider undertaking the revision surgery as required.	
7. The Trust should undertake a comprehensive review of its clinical governance processes relating to orthopaedic surgery in order to ensure that it can monitor performance more robustly and detect any issues as early as possible. The clinical governance structure needs to be robust and adhered to so that issues are escalated through appropriate channels.	Review undertaken with Clinical Director of T&O. Introduction of a bi-monthly peer review meeting to: • Review the post-op imaging for all arthroplasty cases undertaken in the preceding 2 months; • Undertake MDT review of complex cases	The implementation of this action will ensure that on an ongoing basis, there is a timely review of clinical outcomes in a peer forum which goes above and beyond the recommendations in the RCS review. This meeting will report via Alert, Advise, Assure (AAA) report to Planned Care Governance which in turn reports to CEC and up to Quality and Safety Committee
8. As part of the review outlined in recommendation 7, the Trust should consider how NJR data is used to monitor performance and drive improvement. It is recommended that their NJR surgeon-level reports are presented in a peer forum annually.	Introduction of an annual peer review forum for surgeons to present their surgeon level reports. Terms of reference agreed at clinical effectiveness committee (CEC) and inaugural meeting date was initially set for October but a new date is currently being sought due to a diary clash.	The meeting will present an appropriate forum for peer scrutiny and opportunity for review should any issues be identified in relation to early failure rates. This meeting will report via Alert, Advise, Assure (AAA) report to Planned Care Governance which in turn reports to CEC and up to Quality and Safety Committee
9. The Trust should also ensure the review of NJR surgeon-level reports are included as part of annual appraisal and that any concerns regarding unexpected or negative trends with this data should be discussed with the relevant surgeon(s). One model the Trust may wish to consider is that the arthroplasty team discuss openly each contributing surgeons report in detail in sheltered time, and the conclusions for each surgeon is included in their appraisal. This will cover	As identified in section 8 – an Annual Peer Review Forum has been established. NJR Surgeon level reports have been and will continue to be discussed in annual appraisals.	Appropriate review of clinical practice will be undertaken with individuals as part of formal appraisal processes.

those eventualities where the appraiser is not an arthroplasty surgeon (or indeed is from a different speciality).		

6. Ongoing actions

There were seven cases identified in the RCS report where they were unable to draw conclusions due to lack of information. Upon receiving the report, the Trust attempted to obtain ongoing care records from other NHS providers where patients continued their care and the Trust are working within the remit of the General Data Protection Regulations (GDPR) and information governance requirements to obtain this information (Recommendation 2).

Early failure of hip and knee arthroplasty is described when revision is required within 5 years of the procedure. Practitioner A left the Trust in 2017 and therefore, patients who remain at risk of early failure were operated on in 2016-2017. The Trust have identified 129 arthroplasty procedures undertaken within this time period where Practitioner A was the primary or secondary operator and attempts will be made to contact each patient that underwent a procedure to offer a clinical review (Recommendation 1).

The Trust are also working with the National Joint Registry (NJR) to confirm all revisions in the last 10 years (Recommendation 1).

7. Summary

Cases have been identified for practitioner A which would suggest that the operative technique may have led to premature failures following surgery and the Trust is ensuring all patients are offered appropriate follow up and duty of candour, where required.

The Trust have accepted and are implementing all of the recommendations from the RCS review.

The Trust have identified and investigated a significant number of cases. The remaining challenge is to identify any further cases where the conduct of the primary procedure may have contributed to premature failure and revision surgery in 2016 and 2017 up until practitioner A left the Trust.

8. Recommendations

It is recommended that the Board of Directors note the outcome of the Royal College of Surgeons review and that steps are being taken to support patients following the outcome of the review.

The Board of Directors is asked to **note** the actions being taken to address the concerns raised in relation to the governance in Trauma and Orthopaedics, which will be subject to further review for assurance post-implementation of the actions.

Clinical Record Review Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Report on 30 clinical records

relating to hip arthroplasty surgery on behalf of Southport and Ormskirk Acute NHS Trust

Report issued: 1 December 2020[1]

A clinical record review on behalf of:

The Royal College of Surgeons of England

The British Orthopaedic Association

Review team:

Mr Robert Kerry FRCS

Mr Ananda Nanu FRCS

PRIVATE AND CONFIDENTIAL

[1] An amended report was issued on 18 March 2021 with amendments to cases A10, A24, A25 and A27, and 3.1 and 3.2 in the Conclusions section

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Contents

1. Introduction and background

On the 14th February 2020, Dr Terence Hankin, Executive Medical Director for Southport and Ormskirk Acute NHS Trust ('the Trust') wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited clinical record review of 29 hip arthroplasty cases[2], which relate to patients who had been under the care of the same consultant orthopaedic surgeon[3]. In particular, the request highlighted specific cases in which there had been a premature failure of primary hip arthroplasty leading to revision surgery. This request was considered by the Chair of the Royal College of Surgeons of England (RCSEng) IRM and a representative of The British Orthopaedic Association (BOA), and it was agreed that an invited clinical record review would take place.

A review team was appointed and an invited review of the cases was arranged, an appendix to this report lists the members of the review team. The review team reviewed the 30 clinical records provided for the purposes of addressing the terms of reference agreed. The reviewer's conclusions of the overall care provided are outlined in section three, and their comments on each case are outlined in section five.

The Trust should consider the conclusions drawn in this report, as well as the other information it holds, and ensure patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20, in respect of their Duty of Candour. The Trust should also consider the conclusions in this report as they relate to the wider provision of the hip arthroplasty service and determine whether any actions are required to protect patient safety.

[2] The 30 cases provided to the review included a duplication of patient [redacted]
[3] This surgeon is referred to as 'surgeon one' in this report.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the review between the RCS England and the healthcare organisation commissioning the review.

Review

The review will involve:

- A clinical record review of up to 29 cases of specific cases put forward by the Southport and Ormskirk Acute NHS Trust.

Terms of Reference

In conducting the review, the review team will consider the clinical records provided by the Southport and Ormskirk Acute NHS Trust, including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision making, case selection, operation or procedures;
- Communication and decision making including consent;
- Team working including communication, MDT discussions and working with colleagues; Whether the surgical technique employed by the operating surgeon for the primary arthroplasty led to premature failure of the hip replacement;
- Whether the care or service delivery offered by the Trust was of an acceptable standard including identifying any factors that may have contributed to poor outcomes;
- If there were any actions the service could have taken to prevent these patient outcomes or reduce the likelihood of it happening.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.
- May make recommendations for the consideration of the Medical Director of Southport and Ormskirk Acute NHS Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

3. Conclusions

The following conclusions are based on the information provided in the documentation submitted and the clinical records reviewed. These are overall conclusions based on the sample of cases provided and focus on highlighted areas of concern or improvement. The review team's comments on the care of each patient are outline in section five.

3.1. Overall quality and safety of care provided

The review team would like to highlight that it appeared that the entire patient record had not been provided for review. Where there appeared to be an absence of expected documentation, they have made a note of this in the clinical records notes in section five. This meant that there were instances where they were unable to draw conclusions on all domains of care, and they were unable to draw any conclusions for seven cases[4]. The Trust should review these comments, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episodes.

Notwithstanding the above comments, there was cause for concern identified by the review team in the sample of cases reviewed. Where the concerns identified relate to the surgical technique employed by the operating surgeon, in specific cases and the premature failure of the hip replacements, these are summarised in section 3.2.

The review team noted that a number of the post-operative x-rays showed implants to be in varus[5] and/or having an undersized stem. These were considered to be within the range of outcomes following hip replacement surgery but the review team considered that a pattern of implants in varus and undersized stems was indicative of substandard operative technique. They also considered it important to highlight that misaligned implants and undersized stems are known to contribute to early failure of hip arthroplasty.

The review team also noted that patients in this sample underwent hip arthroplasty using uncemented prostheses. The review team considered that it was important that precise surgical technique was employed for uncemented hip replacements due to the increased risk of failure if the implant is not fitted precisely. The review team were of the opinion that the pattern of implants in varus and undersized stems represented a significant cause for concern given the choice of uncemented implant. The review team also were of the opinion that repeated use of an uncemented implant with suboptimal results, demonstrated poor decision-making and a lack of reflective practice.

The review team noted that there were [redacted] patients[6] in the sample provided that experienced intraoperative fractures of the greater trochanter. The review team were of the opinion that these fractures were within the expected range of outcomes in providing surgical care, and considered that the complications were not necessarily indicative of substandard surgical care.

There were instances where the clinical records did not include patient outcomes, which meant that the review team could not draw conclusions on the overall quality of care. The review team recommended that the Trust reviews all 29 patients' care to ensure they have received appropriate follow-up by the Trust or by another provider[7]. In particular, they would like to highlight that it was important that the Trust confirmed that cases [redacted] had received appropriate clinical follow-up.

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[4] [redacted]

[5] Excessive inward angulation (medial angulation, that is, towards the body's midline)

[6] [redacted]

[7] [redacted]

3.2. Whether the surgical technique employed by the operating surgeon for the primary arthroplasty led to premature failure of the hip replacements

The review team considered that in nine[8] of the cases reviewed, the information provided indicated that a technical error during the arthroplasty surgery likely contributed to premature failure of the hip replacement.

In **case** [redacted], the review considered that the surgical technique employed by the operating surgeon for the primary arthroplasty contributed to premature failure of the hip replacement. This was demonstrated in the image provided which showed the liner not properly seated in an uncemented shell, likely leading to the early failure.

In **case** [redacted], the patient had an undersized left femoral component put in, in varus. The patient was noted to be taking considerable analgesia throughout the post-operative period and describing start up pain. [redacted] had a bone scan because of [redacted] complaints of pain and possibly because of sinkage of the stem. [redacted] underwent a revision of [redacted] hip for presumed infection although the review team noted that there did not appear to be strong evidence of infection. It was concerning that the patient continued to complain of mechanical pain in [redacted] thigh until [redacted] ultimately underwent revision surgery nearly two and a half years following the index procedure, and there did not appear to be recognition of the cause of the ongoing pain.

In **case** [redacted] the review team noted that the cup was very medialised, thinning out the medial wall and anterior column. The cup did not appear to be secure, and subsequently moved - a discontinuity in the anterior column line was visible in x-rays prior to the revision surgery to a dysplasia cup. The review team were of the opinion that the technique used for the primary option chosen for the primary operation was unsatisfactory.

In **case** [redacted] the patient had a left uncemented [redacted] Pinnacle 36mm metal on metal total hip replacement with an early dislocation during the index admission, and ultimately returned to theatre where the stem was found by the operating surgeon to be anteverted and this was revised, but the cup which appeared to be very significantly vertical on the available x-rays was unrevised. The patient experienced pain on a regular basis post-operatively which the review team considered could be attributed to the mal-position and subsequent compensatory lengthening to increase the stability. It is the opinion of the review team that at the exploration of the hip on [redacted], both the stem and the cup should have been revised.

In **case** [redacted] there appeared to have been a technical error in seating of the ceramic liner in the acetabular shell which led to premature implant failure.

In **case** [redacted], following the patient's [redacted] hip replacement [redacted] side) the liner was eccentric on the right (recently replaced) hip and unfortunately no x-rays were provided beyond this period but [redacted] was thought to have had a ceramic liner fracture in November 2016. The ceramic liner in the right hip has been placed eccentrically thus leading to this mal-position leading to a significantly increased likelihood of breaking and of wear between the ceramic head and the native metal of the acetabular component. This has possibly been attributed to a fall (which may well have occurred but it was difficult to be certain whether the fall was caused by the ceramic fracture or contributed to it) but in either instance, once the ceramic liner has been fractured it is imperative that the patient is brought in for an immediate revision as the ceramic particles are highly abrasive and will lead to destruction of both the acetabulum and the bearing surface and making subsequent revision difficult as damage to the trunnion may occur requiring a complete revision of both the cup and a well fixed femoral component.

[8] [redacted]

In **case** [redacted], the review team were concerned that the imaging showed that the ceramic liner was improperly seated leading to premature failure. They considered that this was due to a technical error.

In **case** [redacted] an undersized femoral stem implant may have contributed to a [redacted] hip dislocation, however the review team noted that they could not make a definitive assessment that dislocation was attributable to this as they were not in possession of the x-rays.

In **case** [redacted] an undersized femoral stem implant may have contributed to a femoral loosening, however the review team noted that they could not make a definitive assessment of this from review of the limited clinical records available to them.

3.3. Whether the care or service delivery offered by the Trust was of an acceptable standard including identifying any factors that may have contributed to poor outcomes, and if there were any actions the service could have taken to prevent these patient outcomes or reduce the likelihood of it happening

The review team were concerned by the pattern of suboptimal surgical technique and outcomes demonstrated in the sample of cases, and considered that there was an indication of cause for concern about the clinical governance systems for patients undergoing arthroplasty surgery. It was the expectation of the review team that every patient undergoing revision hip replacement surgery would be discussed at a Multidisciplinary (MDT) meeting prior to surgery. They also considered it good practice that outcomes following revision surgery would be reviewed or audited. The review team considered that a pattern such as was demonstrated in this sample may have been identified through such a process, and steps taken to improve the quality of care provided to patients. The review team considered that the Trust should review its clinical governance processes for trauma and orthopaedic surgery as a matter of urgency.

The review team also considered that use of National Joint Registry (NJR) data to identify potential issues or areas for improvement was important in providing high quality and safe care. To support the Trust in the early identification of patterns that may be of concern, the review team recommended that all consultant orthopaedic surgeons present their surgeon-level NJR data to their peers annually. The review team also considered it imperative that every consultant orthopaedic surgeon discusses their NJR surgeon-level report as part of their annual appraisal, and steps are taken to support the surgeon to improve outcomes if a concern is identified during this process.

4. Recommendations

1. The review team have formed conclusions on the care provided to this sample of patients. The Trust should consider the views of the review team, as well as the other information it holds, and on this basis provide further follow-up of any patients for which it considers this to be required. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20[9].

2. The review team were unable to determine the outcome for a number of the patients. The Trust should review the care of these patients[10] to ensure they are aware of the outcomes and that the Trust has met its ethical and legal obligations, including those outlined in recommendation 1.

3. The Trust should consider with whom the conclusions of this report relevant to the operating surgeon should be shared for the purposes of protecting patient safety, including the operating surgeon's responsible officer and any other known places of work, taking into account the Trust's legal responsibilities towards the confidentiality of their patients and staff.

4. The Trust should share and discuss the conclusions in this report that relate to the practice of the operating consultant surgeon, with the operating consultant surgeon to allow them the opportunity to reflect on the contents of the report and consider how they can learn from it and develop their practice.

5. The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode(s).

6. The Trust should review the MDT and pathway arrangements for those undergoing arthroplasty revision surgeries to ensure that there is appropriate MDT-input into decision-making for every patient.

7. The Trust should undertake a comprehensive review of its clinical governance processes relating to orthopaedic surgery in order to ensure that it can monitor performance more robustly and detect any issues as early as possible. The clinical governance structure needs to be robust and adhered to so that issues are escalated through appropriate channels.

8. As part of the review outlined in recommendation 7, the Trust should consider how NJR data is used to monitor performance and drive improvement. It is recommended that their NJR surgeon-level reports are presented in a peer forum annually.

9. The Trust should also ensure the review of NJR surgeon-level reports are included as part of annual appraisal and that any concerns regarding unexpected or negative trends with this data should be discussed with the relevant surgeon(s). One model the Trust may wish to consider is that the arthroplasty team discuss openly each contributing surgeons report in detail in sheltered time, and the conclusions for each surgeon is included in their appraisal. This will cover those eventualities where the appraiser is not an arthroplasty surgeon (or indeed is from a different speciality).

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[9] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

[10] As highlighted in section three

5. Guidance for the healthcare organisation

5.1. Responsibilities in relation to this report

This report has been prepared by the Royal College of Surgeons of England and the British Orthopaedic Association under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[11]

5.2. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues, the Royal College of Surgeons of England will follow up with the healthcare organisation to request confirmation that timely action has been taken to address these recommendations.

If further support is required the College may be able to facilitate this. Additionally, if it is considered that a further review would help to assess improvements that have been made the College's Invited Review service may be able to undertake this.

[11] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

6. Clinical record review notes

The following notes were made by the clinical reviewers with regard to the cases under review. These cases have been listed using the identifiers in the Clinical Record Review Log provided by the Trust. The patient numbers that relate to each case can be found in the log.

Case A1 [redacted]

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Case A2 [redacted]

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Case A3 [redacted]

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Case A4 [redacted]

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Case A5

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Case A6

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Case A7 [redacted]

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Case A8 – [redacted]

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Case A9 [redacted]

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Case A10 – [redacted]

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Case A11 – [redacted]

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Case A13 [redacted]

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Case A15 [redacted]

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Case A16 - [redacted]

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Case A17 [redacted]

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Case A18 [redacted]

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Case A19 [redacted]

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Case A20 - [redacted]

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Case A21 [redacted]

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Case A22 [redacted]

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Case A23 [redacted]

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Case A24 [redacted]

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Case A25 [redacted]

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Case A26[redacted]

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Case A27 [redacted]

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Case A28 [redacted]

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Case A29 - [redacted]

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Case A30 – [redacted]

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Appendix A – Royal College review team

Mr Robert Kerry FRCS **The Royal College of Surgeons of England**

Mr Kerry has been a consultant orthopaedic surgeon in Sheffield since 1998 and has a special interest in hip and knee arthroplasty surgery and, in particular, cases involving infection and massive bone loss. He was Clinical Director from 2007-2010 and has an active interest in the fellowship training programme, outcome measures and tariffs in orthopaedic surgery.

Mr Ananda Nanu FRCS **British Orthopaedic Association**

Mr Nanu trained in the north-east of England and Liverpool where I completed a Master's Degree in orthopaedic surgery. He went on to lead the pelvic and acetabular reconstruction service in Sunderland, providing a surgical service for the management of this complex traumatic injury until the establishment of the MTC in Newcastle.

Mr Nanu is on the Council of the Royal College of Surgeons of England and has been a Council Member of the British Orthopaedic Association since 2013 and a member of the Executive since 2015. He served as the President of the British Orthopaedic Association for 2017-2018 during the Centenary of the BOA.

He has also contributed to several publications and is a chapter author of the Oxford Textbook of Orthopaedics (2011 edition).

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB122/21**	**FOI Exempt**	**NO**
Report Title	**2020/21 INFECTION PREVENTION AND CONTROL ANNUAL REPORT**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapy & Governance		
Lead Officer	Andrew Chalmers, Consultant Nurse/Deputy Director - Infection Prevention & Control		
Action Required	☐ **To Approve** ☐ **To Assure**	☑ **To Note** ☑ **To Receive**	

Purpose

To provide an update on the Trust's performance in relation to Infection Prevention and Control (IPC) in 2020/21

Executive Summary

This document reports on the 2020/21 annual IPC programme (which in 2020/21 was a Trust Quality Priority) and includes the actions taken to ensure that the Trust meets the requirements of NHS England/Improvement and the Care Quality Commission in relation to IPC. The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- The Revised National Cleaning Standards 2014
- Antimicrobial Stewardship: "Start Smart – Then focus" 2011 (updated March 2015)
- NHS England IPC BAF May 2020
- Infection Prevention & Control Board Assurance Framework (February 12, 2021. V1.6)

The Hygiene Code is underpinned by ten compliance criteria which this year's programme of work is mapped to; this will ensure that the Trust continues to maintain and strengthen its compliance.

Progress

The Trust has made improvements in a number of areas not withstanding responding to an international pandemic including:

- Of the 40 identified actions in 2019/20 there were 32 designated as Green and 8 Amber; at the close of 2020/21; there were only 2 that remained Amber (IPC annual mandatory training & IPC Link Worker meetings)
- C diff numbers increased from 31 in 2019/20 to 34 in 2020/21 however the lapses in care have reduced from 15 to 8 which Is an improvement
- Increased collaboration across the Trust and with key external partners e.g. CCGs and NHSEI
- RCA process for HCAIs has become more clearly defined and more workable
- Pandemic response has led to innovations in process as well as technology
- MSSA bacteraemia has reduced from 13 in 2019/20 to 8 in 2020/21. Trust rate per 100.000 bed days was 10.4 and the NW average was 18.2
- Slight reduction in E coli bacteraemia cases by 1 in comparison to previous year
- Blood culture contamination rate has dropped from an average of 7% in 2019/20 to 5.5% in 2020/21 – the PEFs (Practice Education Facilitators) with the IPC team continue on strategies to reduce this further

Southport and Ormskirk Hospital NHS Trust

Areas requiring further improvement

- Improving IPC Level 2 Mandatory Training
- Re-establishing the IPC Link Workers
- Focus on: C diff reduction using the Trust C diff action plan, improving cannulation and catheter documentation and management as well as considering actions required with respect to COVID and providing adequate ventilation.
- The PEFs (Practice Education Facilitators) with the IPC team continue on strategies to reduce blood contamination rates further

Recommendations

The Board of Directors are asked to **receive** and **note** progress in relation to the Infection Prevention and Control (IPC) Annual Report and agree the measures proposed within the report for further progress

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Andrew Chalmers	Bridget Lees

Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk Hospital NHS Trust
2020/21 Infection Prevention and Control (IPC) Annual Report

Executive summary
This document reports on the 2020/21 annual IPC programme, which has been a Trust Quality Priority since 2019/20 and includes the actions taken to ensure that the Trust meets the requirements of NHS England/Improvement and the Care Quality Commission. It also includes an update against the current IPC BAF (Board Assurance Framework).

The IPC programme was based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- The Revised National Cleaning Standards 2014
- Antimicrobial Stewardship: "Start Smart – Then focus" 2011 (updated March 2015)
- NHS England IPC BAF May 2020
- Infection Prevention & Control Board Assurance Framework (February 12, 2021. V1.6)

The Hygiene Code is underpinned by ten compliance criteria which this year's programme of work is mapped to; this will ensure that the Trust continues to maintain and strengthen its compliance.

Highlights which confirm continued progress in IPC Measures include:

- Of the 40 identified actions in 2019/20 there were 32 designated as Green and 8 Amber; at the close of 2020/21 there were only 2 that remained Amber (IPC annual mandatory training & IPC Link Worker meetings)
- C diff numbers increased from 31 in 2019/20 to 34 in 2020/21 however the lapses in care have reduced from 15 to 8 which Is an improvement – the IPC team are working with the CCGs to identify measures across the health economy to reduce the overall numbers
- Slight reduction in E coli bacteraemia cases by 1 in comparison to previous year
- MSSA bacteraemia reduced from 13 to 8
- Blood culture contamination rate has dropped from an average of 7% in 2019/20 to 5.5% in 2020/21 – the PEFs (Practice Education Facilitators) with the IPC team continue on strategies to reduce this further

Monitoring delivery of the program
Progress against the programme was monitored by the Infection Prevention and Control Assurance Group.

Abbreviations used in the document

AMD	Associate Medical Director
BAF	Board Assurance Framework
CBU	Clinical Business Unit
CPE	Carbapenemase Producing Enterobacteriaceae
DIPC	Director of Infection Prevention and Control
DONQ	Director of Nursing and Quality
HAIR	Healthcare-associated infection Review
HCAI	Healthcare-associated Infection
HEAT	Hygienic Environment Action Team

HON	Head of Nursing
IPCAG	Infection Prevention and Control Assurance Group
IPCT	Infection Prevention and Control Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PICC	Peripherally-inserted central catheter
RCA	Root Cause Analysis
SIRG	Serious Incident Review Group
SSI	Surgical Site Infection

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
1. Systems in place to manage and monitor the prevention and control of infection							
Hold four IPCAG meetings, the minutes of which are submitted to the Quality and Safety Committee with monitored attendance The IPCAG will receive from the IPCT, CBUs and groups reporting to the IPCAG quarterly information on: ○ HCAI performance ○ Audits & surveillance ○ Progress on action plans ○ Outbreaks & Incidents ○ New publication relating to IPC/Microbiology	DIPC	Quarterly	Green	Green	Green	Green	IPCAG meetings were held in May, June, July, August, October, December 2020 and February 2021; minutes were submitted to the Quality & Safety Committee.
Attendance at and provision of quarterly reports to the Quality and Safety Committee	DIPC	Quarterly	Green	Green	Green	Green	1st Quarter submitted to 24/8/2020 meeting. 2nd and 3rd quarter submitted. The IPC BAF has been submitted quarterly and the end of year annual report to be submitted to the 28/6/21 meeting. The DIPC also provides a monthly update from the monthly IPC performance report.
Present the 2020/21 annual programme to the Trust Quality and Safety Committee	DIPC	Annually	Green				2019/20 programme submitted to 24/8/2020 meeting and 2020/21 programme to be submitted to 28/6/21 meeting.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Collate and submit mandatory surveillance data as directed by NHS England onto the PHE data capture system	IPCT	Monthly	Green	Green	Green	Green	Monthly surveillance data submitted by the IPC team and approved by the DIPC. Data also provided to the CCGs and is widely distributed to Trust Managers and Directors
Pharmacy teams to undertake quarterly antimicrobial audits with the support of a Microbiology Consultant and the antimicrobial pharmacist	Antimicrobial Pharmacist	Quarterly	Green	Green	Green	Green	Antimicrobial audit completed 1st and 2nd quarters – reported in IPCAG meeting. 3rd and 4th quarter reports completed and reported through Antimicrobial Stewardship Meeting to IPCAG.
Clinical teams within CBUs in collaboration with the Risk and IPC teams to lead on the RCA of each case of hospital apportioned *C difficile*, MRSA bacteraemia, device related bacteraemia and gram negative bacteraemia to establish the root cause and identify any lessons learnt	DIPC	Weekly reviews	Amber	Amber	Amber	Green	By the end of the 1st quarter a number of RCAs have been completed and meetings held to work through the processes so that these can be reviewed more efficiently working with the Risk department, CBUs and the DIPC. Weekly reviews continued in 2nd and 3rd quarters, however still dealing with backlog of COVID19 RCAs, hence NHSP IPC nurse working through the backlog and processes further updated through Quality, Risk and IPC. In 4th quarter RCA cases reviewed in Harm Free Care IPC meetings and strategy produced to streamline future RCA meetings as organised through IPC and the CBUs. Screening process in place for COVID19 nosocomial cases

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
IPC Team will maintain professional competence by undertaking relevant training and attendance at IPS/HIS Conference for Professional updating	IPCT	Annually	Green	Green	Green	Green	IPC conference for 2020 has been postponed however there will be a virtual HIS conference later in the year. The IPC nurses continue to attend remotely held teleconferences mostly to do with COVID19 in Quarter 1 and maintain their professional updates through professional journals and PHE/NHSEI/NICE guidance. 2nd and 3rd quarters – emphasis continues to be on remote learning and on COVID19, however IPCN's are members of IPS, HIS and RCN and are therefore staying current with journals and attendance at regional meetings through MS Teams. 4th Quarter IPC team continue to stay current with attendance through MS Teams at regional meetings and also webinars. In addition involved in research with the assistance of the trust Librarian and through professional groups and journals and networking.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections							

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Facilitation of IPC (formerly HEAT) Inspections within clinical settings with reports to the IPCAG	IPCT	Monthly	Green	Green	Green	Green	1st quarter the IPC team with CBU Matrons have completed inspections which are reported on the IPC monthly performance reports. 2nd quarter IPC audits continued. 3rd quarter IPC nurses reduced by half due to retirement and resignation of the IPC Matron and Surveillance Nurse, hence Quality Matrons proceeded with Perfect Ward IPC Audits. 4th quarter audits continued by Quality Matrons; however, this will return to the IPC team once the new IPC Matron and seconded Specialist nurse have completed their orientation period.
IPC Team support and attendance at Water Safety Committee	IPCT	Quarterly	NA	Green	Green	Green	1st Quarter due to the Covid19-19 Pandemic the water safety group didn't meet in the 1st quarter, however in June the IPC Nurse Consultant met with the Water Safety Consultant to review audit Next meeting scheduled in August. 2nd and 3rd quarter Water meetings proceeded as planned with updated risk assessments and flushing procedures. 4th quarter meeting held on 5/3/21 – no specific issues to highlight.
IPC Team support and attend the Decontamination Committee	IPCT	Bi-monthly	NA	Green	Green	Green	Due to the Covid19-19 Pandemic the Decontamination group did not meet in the 1st quarter, however there is a meeting scheduled in 16/7/2020 (2nd quarter) and 3rd quarter meeting scheduled for 7/12/2020. 2nd and 3rd quarter meetings chaired by new decontamination lead (ADO for Planned Care), 4th quarter meeting planned for March 2021 rescheduled and held 12/4/2021.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Provide expert advice to all service developments to ensure infection risks are considered, in particular in the built environment from planning stage to commissioning	IPCT	Ad hoc	Green	Green	Green	Green	Due to the Covid19-19 Pandemic some of the planned schemes have been postponed, however irrespective of this there have been many projects completed and are in process due to the pandemic that the IPC team has provided advice on – these include the segregation and social distancing work done in AED and many other sites throughout the Trust. In addition the installation of a showering/toilet and sluice area in ward 1, the relocating of CCU onto 7A and the planned reconfiguration of wards A & B at ODGH and the proposed ward reconfigurations to accommodate increased isolation provision at SFDGH. 1st and 2nd quarters work progressed mostly providing Covid19-19 secure areas, but also looking forward to installation of waste rooms/lockers, Spinal isolation rooms, AED cubicles, MDU refurb at ODGH. 3rd & 4th quarter's completion of work to improve ventilation and environment in AED. Continue to review and provide advice in spinal unit for isolation rooms and decontamination area. Review plans to complete refurbishment work on Southport site and to include deep clean process.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Review of cleaning products and practices in line with national guidelines and scientific evidence	IPCT	Ad hoc	Green	Green	Green	Green	Facilities have been reviewing and updating their processes with respect to the draft new national cleaning standards – the IPC team have provided support and facilitated meetings where these changes have been addressed, as well as providing advice and reviewing the cleaning products used. 2nd and 3rd quarters reviewed the schedules and practises to ensure appropriate cleaning in all areas; included the introduction and use of NHSP Domestics. 4th quarter increased cleans across the ward in-patient areas and domestics on hand in high risk areas to clean frequent touched surfaces. Added 2 additional hydrogen peroxide vapour disinfecting units – these units are effective against spores as well as bacteria and reduce the time needed when decontaminating a side room where there has been a patient with C diff infection.
3. Provide suitable accurate information on infections to the patient, public and other service providers							
Work with PALs, Complaints, Risk and Communication teams to provide timely and accurate information to press enquiries, FOI requests, patient concerns and complaints	IPCT	As required	Green	Green	Green	Green	The IPC team provides information and assists with complaints and FOI requests, and works with PR and Coms with respect to press releases as required all of which have been critical during the Covid19-19 pandemic. 2nd and 3rd quarters continued to work with and provide information regarding complaints, queries and FOI requests. 4th quarter IPC team responded to FOI requests and assisted with complaints.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Patient information leaflets to be available on the Trust website	Comms Team IPCT	As required	Green	Green	Green	Green	Patient leaflets available on MRSA, C diff, Norovirus and Influenza. Information on IPC practices and hand hygiene also available in-patient admission booklets. Also utilise NHS and PHE leaflets on CPE, VRE and food borne illnesses. During the coronavirus pandemic information leaflets have been provided to patients and those requiring screening with input from the Clinical Reference Group.
Provide IPC data to CBUs for local information boards for clinical areas	IPCT	Monthly	Green	Green	Amber	Green	Monthly IPC Performance report distributed across the Trust In 3rd quarter data submitted to PHE DCS and Trust IPR, however full monthly report not distributed due to reductic in IPCNs and Covid19-19 pressures. 4th quarter Monthly IPC performance reports distributed a replacement IPC Matron and band 6 seconded nurses commence employment in February 2021.
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion							
Continue inserting information stickers for C diff in the health records of patients and provide relevant patient information leaflets	IPCT	As required	Green	Green	Green	Green	Every in-patient who has a community or hospital acquired C diff infection is noted in the patient's notes and an information leaflet is provided to each affected patient

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Flagging on patient administration system (Medway) of C diff, MRSA, CPE, VRE or other significant organisms that have an infection risk for appropriate management on readmissions	IPCT	As required	Green	Green	Green	Green	Every patient who is colonised or infected with MRSA, C diff, CPE, VRE or other significant multidrug resistant organism is alerted on Medway so that clinicians are alerted on subsequent admissions so that the appropriate precautions can be taken.
Raise awareness on current IPC issues within the Trust; - Monthly Performance Reports - Mandatory Training to include current issues - Themed articles to be published in Trust News - Table top training and ward visits - Ad-hoc drop-in training sessions as required when new situations arise	IPCT	Monthly As required	Green	Green	Green	Green	The IPC team identifies issues and learning points from monitoring, surveillance, inspections, RCAs, PIRs, incidents and outbreaks and incorporates these into the monthly performance report. During the Covid19-19 pandemic the IPC team in conjunction with Gold and Silver Command have provided news bulletins, posters, handouts, frequent ward and department visits to train, support and inform, fit test training for disposable respirators, training and SOPs for powered air purifying respirators and U-tube videos. During 1st quarter the usual face to face IPC training has been replaced by IPC E-learning and hand hygiene practicums have been ward/department based – this continued through 2nd, 3rd and 4th quarters.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to others							
Results of correct isolation on admission (MRSA) and isolation of diarrhoea until after specimen result is known, published in monthly performance report	IPCT	Monthly	Green	Green	Amber	Green	Information provided to CBUs in each monthly performance report. In 3rd quarter full monthly report not distributed due to reduction in IPCNs and COVID19 pressures. In 4th quarter monthly performance reports completed and distributed.
All patients screened positive for MRSA and previously known to be MRSA positive to be prescribed suppression therapy. IPCT audit compliance with MRSA Pathway	IPCT	Monthly	Green	Green	Green	Green	The IPC team provides a monthly report to CBUs on compliance of the MRSA pathway. In 2nd and 3rd quarters IPC team providing care plans and inserting MRSA stickers into case notes of patients identified as MRSA positive – process continued in 4th quarter.
Action plans for results of MRSA Pathway Audits presented at IPCAG	HON	Quarterly	Amber	Amber	Amber	Green	Primarily this is an issue with Planned and Urgent Care CBU's with Planned Care averaging 76% over the 1st quarter and Urgent Care 53%. Overall the compliance has improved from 57% to 64% with Urgent Care improving from a low of 42% in May to 67% in June as the Urgent Care Matrons have worked on their action plan to improve MRSA pathway documentation. 2nd and 3rd quarters continued to show a lot of variation ranging from 48-71%, hence continues to be an issue in planned and urgent care that needs addressing. Continued issues identified in 4th quarter – urgent care provided a plan for improving compliance through CBU Matrons

IPC Team to facilitate comprehensive surveillance system for HCAI with monthly reporting	IPCT	Monthly	Green	Green	Green	Green	The IPC team facilitates HCAI surveillance and reports to PHE and CCG, in addition to identifying issues and instigating actions to provide resolutions.

Maintain close links with relevant agencies (Public Health England, NHSE/I, CCGs and providers of Community IPC Services) to ensure that robust communication channels are maintained	IPCT	As required	Green	Green	Green	Green	The IPC team maintains close links with local agencies with frequent communications through telephone, e-mails and MS Teams meetings.

6. Ensure all staff are fully involved in the process of preventing and controlling infection							
A requirement to comply with infection prevention and control is included in all job descriptions: Zero tolerance to non-compliance with IPC practices to be monitored and following procedure introduced; 1st observation - File note and discussion with line manager 2nd observation - Interview with higher manager/director 3rd observation - Disciplinary process commenced	Human Resources Matrons Consultants EMD DON IPCT	As required	Green	Green	Green	Green	The IPC nurses have identified issues regarding hand hygiene, PPE and cleaning, however it has been our experience that staff have been responsive to reminders and instructions and incidents haven't needed to be escalated.

Clinical and Nursing staff attend RCA meetings to ensure robust process	Matrons AMDs	As required	Amber	Green	Green	Green	During the 1st quarter there have been 4 RCA meetings and in addition to this the Consultant Microbiologist and Urgent Care Matron have reviewed some of the back log of cases. All of these cases are initially reviewed by the Consultant Microbiologist and the IPC team and information fed back to the clinical and nursing teams prior to an RCA being requested, however there is a need for improved clinical engagement so that clinical learning can be identified and shared so that improvements can be made. At the end of June there have been further meetings to devise a way forward which should see improved engagement in quarter 2. Quarters 2 and 3 showed improvement in RCA attendance primarily from nursing staff but also doctors with respect to C diff. In 4th quarter RCA cases reviewed in Harm Free Care IPC meetings and strategy produced to streamline future RCA meetings as organised through IPC and the CBUs. Screening process in place for COVID19 nosocomial cases.
Local and personal IPC Performance is discussed at staff appraisal	All Managers	As required	Green	Green	Green	Green	IPC is part of staff appraisals who work in a clinical setting
7. Provide or secure adequate isolation facilities							

IPCT and Bed Managers maintain the isolation information spreadsheet on the Trust Intranet to ensure that availability of isolation facilities is apparent	IPCT Clinical Coordinators	Daily	Green	Green	Green	Green	The isolation room spreadsheet is updated by the IPC team each morning from the Clinical Coordinators night time update and is updated throughout the day by the IPCT in response to patient and laboratory updates and then a final review in the afternoon with each ward being contacted. The IPC nurse working on a weekend will also update the spreadsheet with any relevant changes identified while working through laboratory results. The Trust's 8 pop-up isolation rooms (Redirooms) continue to be used around the Trust as the need arises – most frequently on 14A and Spinal Injuries. Following the initial success of the Redirooms a further 5 were purchased – the Trust were the pioneers in the UK to use this equipment and have provided advice to other Trusts throughout the country as well as working with the manufacturer to make improvements.

IPCT provide advice and support on the management of infectious patients during an increased incidence of infection or outbreak to contribute to management of appropriate usage of the side rooms	IPCT	As required	Green	Green	Green	Green	The IPC team is continually gathering syndromic and laboratory intelligence with respect to potential incidences and outbreaks and initiates investigations and incidence and outbreak meetings as required. 1st quarter: The biggest challenge has been responding to sporadic cases of COVID19-19 wherein initial testing has been negative then follow-up testing is positive. Typically this is due to the shortfall in the sensitivity of the test, or may be indicative of patients admitted in an incubation period. However, with the IPC processes put in place there have been no reported outbreaks except for a cluster (as agreed by NHSE/I) of 2 cases on ward 9B/FESS – this was a cluster as opposed to an outbreak as there were no links between the two cases and all other patients tested negative. Through 2nd, 3rd and 4th quarters daily outbreak meeting re pandemic led by Silver command. Redirooms utilised as described above, also installed isolation screens between bed spaces in in-patient bays – the Trust again has been an innovator in this area to maintain the safety of our patients.

Patients identified with Type 5-7 stools (as defined by the Bristol stool Chart) are isolated within 2 hours	Nurse in charge of Ward Clinical Coordinators	As required	Amber	Amber	Amber	Green	Reported on the monthly performance report 1st quarter averaged 57%. This is based on small sample of patients (23) who have tested positive for C diff antigen and whether they were isolated prior to the result being reported which can take 12-24 hours. Of those not isolated the majority (80%) came from Urgent Care wards with 20% from Planned Care wards. Urgent care is reviewing its side room capacity and how this can be improved based on the needs of the different specialities – this is in conjunction with winter planning and the COVID19 pandemic. 2nd and 3rd quarters ranged from 25-80% of patients being isolated prior to C diff antigen being reported; once it is reported then typically the patient is isolated within this time frame. 4th quarter much improved results with 67% in February and 100% in January and March.

8. Secure adequate access to laboratory support as appropriate							
Laboratory standard operating policies and procedures meet Clinical Pathology Accreditation standards	Lab Manager Contract Monitor	As required	Green	Green	Green	Green	The laboratory has been inspected and meets the required standards
Issues with respect to provision of laboratory service to be monitored by the Trust Contract Monitor so as to ensure the provision of an adequate level of service that will ensure that Trust IPC needs are met	DIPC IPCT Contract Monitor	As required	Green	Green	Green	Green	The laboratory contract is monitored by the Trust Contract Monitor and the IPC Consultant Nurse maintains close contact with the laboratory managers
9. Have and adhere to policies and protocols for the prevention and control of HCAI							
IPC policies include the IPC Policy, Isolation Policy, Management of Gastroenteritis, Influenza Policy, and Hand Hygiene Policy, there is also a recent Coronavirus policy and these are backed up by the Infection Prevention and Control Manual which provides guidance on all other aspects of Infection prevention and Control	IPCT	As required	Green	Green	Green	Green	The monitoring of these policies is through IPC audits which are reported in the monthly IPC performance reports

Compliance with the Hand Hygiene Policy is audited each month and results are published in the monthly performance reports	Link Workers IPCT	Monthly	Green	Green	Green	Green	1st quarter average 99%. This is an exceptional result, however due to the COVID19 pandemic we stopped the link workers going from ward to ward hence in April only a few sites got surveyed, therefore in May and June the link workers audited their own areas (65% of audits completed in May and 87% in June) – there was the occasional bad audit which resulted in further training being provided and follow-up audits being carried out. 2nd and 3rd quarters high level of compliance. Continued high level of compliance in quarter 4 averaging 99%
IPCT Annual Audit Programme	IPC Team	Monthly	Green	Green	Green	Green	The IPCT audits are completed monthly and reported on the IPC Monthly Performance report. The Trust has invested in a ward audit package called Perfect Ward – in quarter 2 the IPC team will start utilising the IPC audit within Perfect Ward which will require an update to the annual audit programme. 2nd and 3rd quarters IPC audits continued, however Perfect Ward IPC audit completed by Quality Matrons. Quarter 4 audits continued as listed.
10. Ensure so far as is reasonably practicable that healthcare workers are free of and are protected from exposure to infections during the course of their work, and that all staff are suitably educated in the prevention and control of infection							

All staff must attend IPC training at induction; following induction clinical staff and non-clinical staff who work in a clinical environment are required to have annual updates. Attendance is monitored at the CBU and Trust Quality and Safety meetings	Assistant Directors of Operations	Yearly	Amber	Amber	Amber	Amber	Since the 1st quarter was severely affected by the COVID19 pandemic the above training has been provided through electronic means, however the new doctor induction scheduled for July/August will be conducted face to face with social distancing measures in place. The percentage uptake for IPC mandatory training continues to be approximately 75%. IPC training is primarily through E-learning with level 1 training nearing 100% and level 2 improving slightly to 78% for 2nd and 3rd quarters. In 4th quarter level 2 training in February improved and reported as 80.14% with level 1 training dropping to 91-92%. The Trust target for training 90%.
Update mandatory IPC training for clinical and non-clinical staff as per Trust training needs analysis to include; - Feedback on performance - Incidents including RCAs - Audit results	IPCT	Monthly	Green	Green	Green	Green	The electronic mandatory IPC training includes the requirements for level 2 training, however updates on KPIs and learning points from RCAs and incidences are provided through bulletins/notices and pictorial guides. In addition donning and doffing, fit test training for respirators and COVID19 training has been provided at ward and department level.

To continue with the link worker educational programme; - Quarterly meetings. - IPCN to provide educational sessions to support link workers in their role. - Managers to allocate dedicated time for link workers to attend meetings and complete Hand Hygiene audits	IPCT Ward Managers	Quarterly	Amber	Amber	Amber	Amber	Due to the COVID19 pandemic the face to face educational session hasn't been provided in the 1st quarter, however irrespective of this communication has continued to the link workers through alerts and bulletins and during this time period the hand hygiene audits have been updated to include PPE which has had a positive effect. 2nd and 3rd quarters Link Workers updates for Hand hygiene and PPE have been forwarded, otherwise formal meetings continued to be suspended. Quarter 4 continues to be as above.
Provide ad-hoc training as required/need identified	IPCT	As required	Green	Green	Green	Green	During the 1st quarter the majority of the ad hoc training has been COVID19 related, hence training has been provided on the use of PPE, social distancing, cleaning, maintaining a safe workplace and respirator training. 2nd and 3rd quarter adhoc training on face to face level on wards, as well as by trust news which have been distributed in person as well as electronically. Training mostly related to COVID19. Quarter 4 ad hoc training continues as in earlier quarters – there has been an increased emphasis on ensuring that information and education isn't reliant solely on electronic means and that the IPC team and the quality Matrons interact directly with staff in their work places.

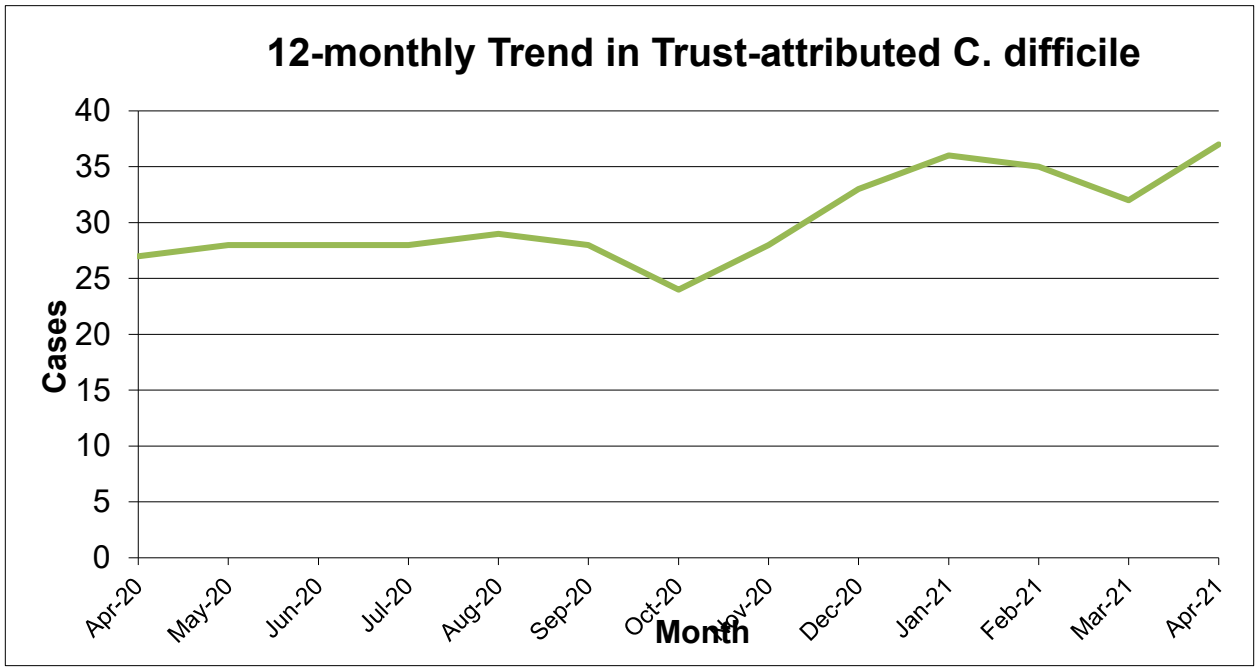
Staff Health and Wellbeing are standing members of the IPCAG and report employee incidences as related to IPC and review policies and guidance	IPCT Staff Health and Wellbeing	Quarterly	Green	Green	Green	Green	A representative from Staff Health and Wellbeing attends IPCAG meetings as scheduled and provides a report.
In collaboration with Procurement review equipment and consumables to ensure that purchases are cost-effective and meet IPC requirements	IPCT Procurement	As required	Green	Green	Green	Green	A representative from the IPCT typically attends the procurement meetings and makes recommendations on clinical equipment and products. During the 1st quarter the IPCT has worked closely with procurement with representatives from both IPC and Procurement attending the Silver and Gold command meetings and operational cells. 2nd, 3rd and 4th quarters have included substantial liaison between procurement and the IPC team even though formal procurement meetings not held.

IPC KPIs and Related Actions

Clostridium difficile Infections (CDI)

In 2020/21 the CDI objective which was carried over from the previous year was to have no more than 16 infections – the previous year 2019/20 the Trust had 31 cases.

The chart below compares the total number of CDI cases for a month by month 12 month period. In the initial half of the year the number of cases is level with a drop in October then steadily starts to climb again. This coincides with the increasing numbers of COVID19 patients and their treatment with antibiotics for possible secondary bacterial infections – increased antibiotic use increases the risk of CDI, as does increased age and frailty with attached comorbidities.



CDI cases against trajectory 2020/21

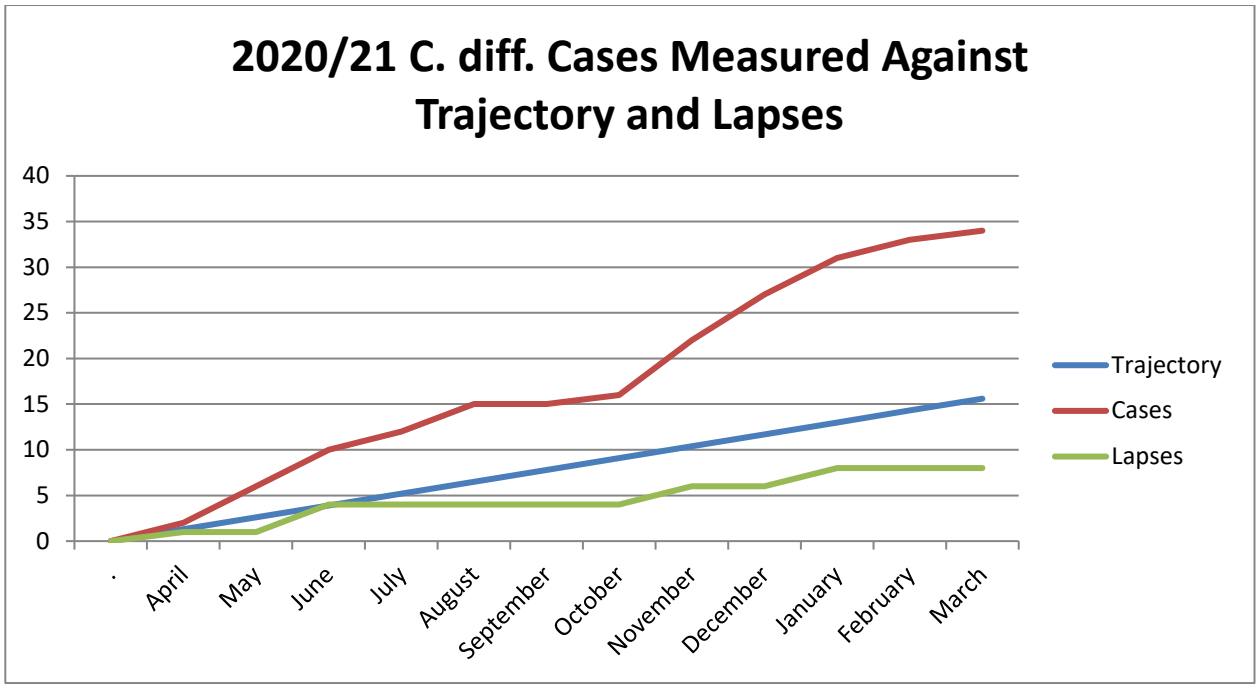
The CDI year to date total is now 34; this includes 13 COHA (Community Onset Healthcare Associated) cases – these are patients that have become positive within 28 days following discharge from hospital. Almost half of the patients are 80 years or older and the average age is 78.

The chart below compares the cumulative number of HOHA (Hospital Onset Healthcare Associated) and COHA CDI infections attributed to the Trust (red upper line), the blue centre line which is the trajectory which shouldn't be exceeded and the green bottom line which is the total number of cases minus the cases for which there was found to be no lapses in care. Each CDI is subject to an RCA (Root Cause Analysis) process which includes senior doctors and nurses as well as the IPC team, Consultant Microbiologist and Antimicrobial Pharmacist. For the 8 cases were lapses were found these included not:

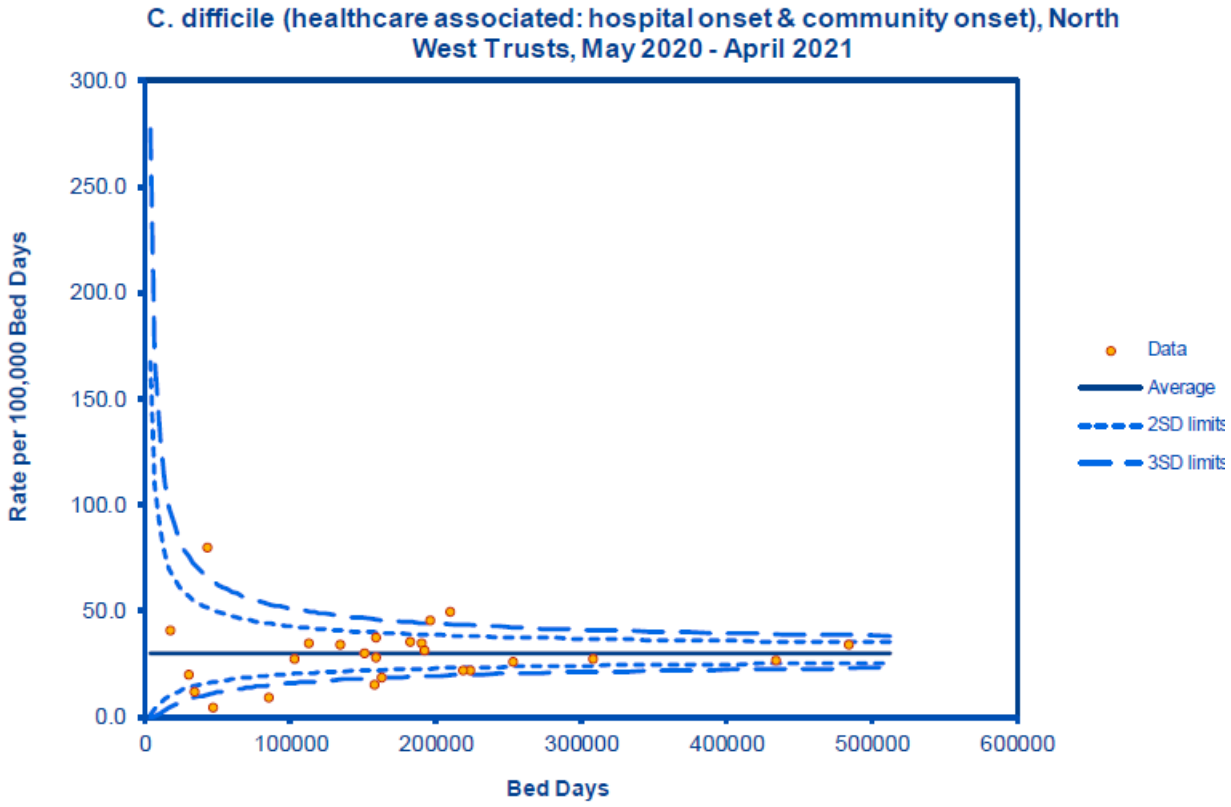
- isolating patients immediately when symptoms of diarrhoea occur
- obtaining a stool specimen when the patient complained of diarrhoea
- prolonged or otherwise inappropriate use of antibiotics

- not obtaining clinical evidence to support the use of antibiotics e.g. if treating a patient for a UTI not obtaining a urine sample, or if treating for a chest infection not obtaining a chest x-ray

The learning from these cases is fed back to the clinical staff involved as well as to the wider Trust through the Monthly IPC Performance Reports which are widely circulated and through the CBU Governance meetings – it is also included when developing training in IPC.



As reported in the most recent PHE NW HCAI report (May 2021) the Trust's rate per 100,000 bed days is 34.5. As can be seen on the chart below the Trust is just above the NW average of 29.9, but is still within the 2 SD (standard deviation) limit.



Source: HCAI Data Capture System

Action: A lot of actions have already been introduced this year such as the reduction in Cephalosporin use and introduction of the Antimicrobial App., sustained use of sporicidal disinfectants and the purchase of improved hydrogen peroxide vapour fogging machines. However going forward into 2021/22 the Trust has produced a CDI action plan in collaboration with the CCGs and presented to NHSEI, to further control and monitor antibiotic use, work with partner organisations to consider appropriate antibiotic prescribing within the local health economy, ensure cleaning standards are met and identify any areas of risk which could be mitigated against e.g. use of sporicidal wipes for commodes, and consider patient nutrition and the introduction of pre and probiotics to enhance and improve gut flora of at risk patients.

MRSA Bacteraemia & MRSA Screening

The most recent MRSA bacteraemia was in April 2020 on ward 14B. This occurrence was in an elderly patient admitted from a care home that was found to be MRSA colonised. The patient had dementia and also had a tracheal stoma which the patient pushed small objects into; as this was an issue in the care home the patient was provided 1 to 1 care. The one lapse in this incident was a miscommunication regarding the patient's MRSA status which resulted in a delay in prescribing MRSA suppression treatment, however this lapse is unlikely to have caused the bacteraemia.

Following this incident in addition to informing the ward of the patient's MRSA status by telephone and placing an alert on Medway (the patient administration system), the IPC team

also places a bright yellow alert in the patients case notes and ensures the ward coordinator is informed in person. The IPC team also monitors MRSA pathways and reports to the ward coordinator if there are any lapses.

In addition to the above case there was also a case in January 2021 on ITU, but following the RCA the reviewers concluded that this was a contaminant and that the patient's treatment was appropriate.

The Trust remains a low risk site for MRSA bacteraemia.

The Trust continues to screen new admissions for MRSA colonisation. Typically more than 95% of eligible patients are screened either preadmission for elective patients, or in AED if an emergency admission. Missed screens are identified by the IPC team who request the ward to complete the screen if so required.

> **Action:** Trust to continue to test eligible patients for MRSA colonisation and provide suppression as required. The IPC team to continue to monitor screening results and will report to the ward coordinator any positives. The team will also place alert stickers in the case notes of positive patients and monitor MRSA pathways.

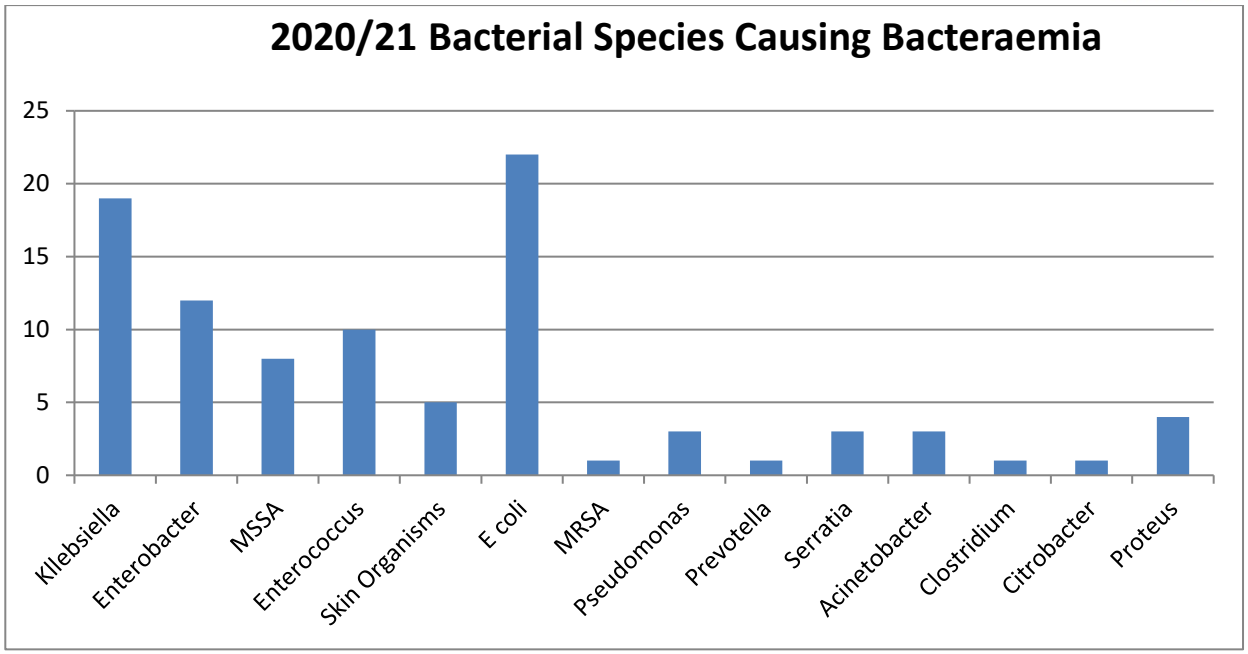
MSSA Bacteraemia

The number of MSSA bacteraemia reduced from 13 in 2019/20 to 8 in 2020/21 which is a significant reduction. The PHE NW annual data for MSSA hasn't been published yet, however in the last quarter of 2020/21 the Trust rate per 100,000 bed days was 10.4 and the NW average was 18.2. No particular common themes for this organism which typically colonises 30% of the population, however it can be the cause of skin infections and can be associated with devices such as intravenous access devices and ventilator associated pneumonias.

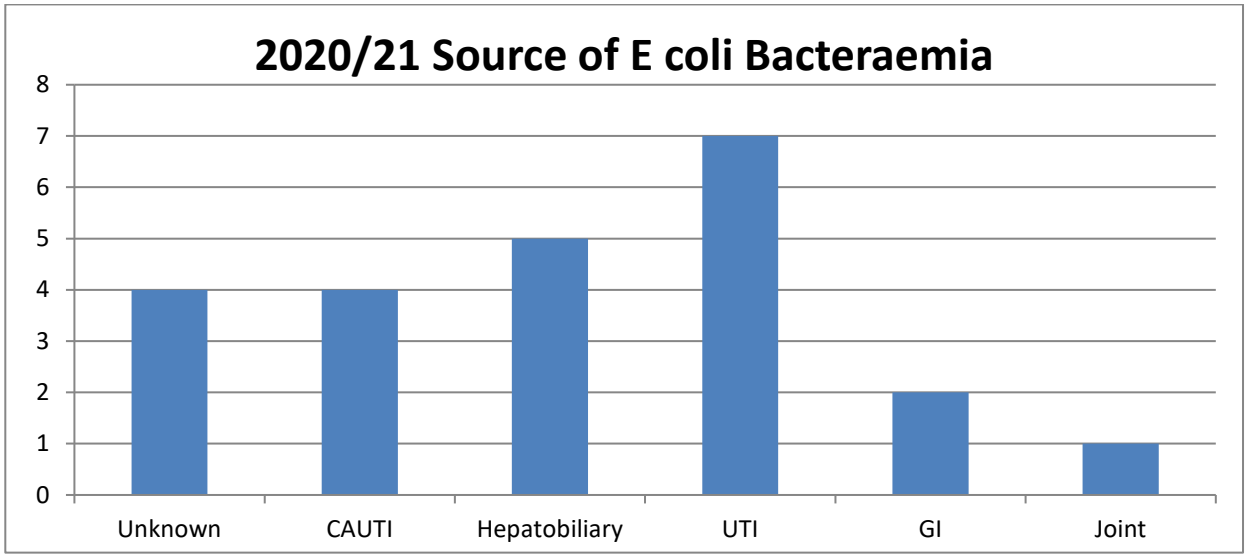
> **Action:** Continue with surveillance and note any trends. As this is an organism that is able to contaminate IV access devices the Trust is once more championing the need for improved compliance with cannula care. This was a previous priority however due to the demands of the Coronavirus pandemic the quality improvement project was put on hold, but has now been reinstated and being led by the Deputy Director of Nursing for Patient Safety n collaboration with the IPC team. The aim of this project is to identify common shortfalls in the documentation and care of cannulae, improve the documentation and verify with staff through education and training the correct methods for insertion and care of cannulae. As this project progresses it will also consider the products currently used and make recommendations based on patient and staff acceptance of the pieces required to safely cannulate.

E coli Bacteraemia

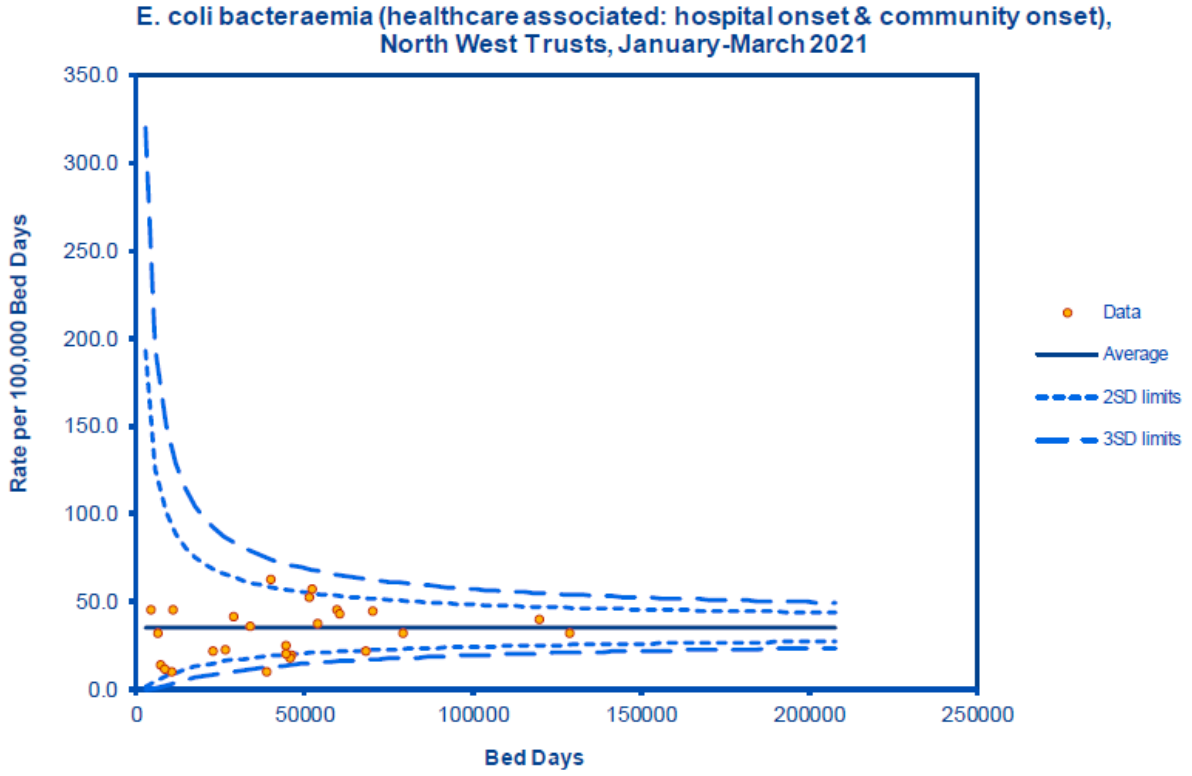
E coli is the most common bacteria to cause bacteraemia as evidenced by the chart below.



This gram negative bacterium colonises the gut and is found in faeces. As can be seen on the chart below the most likely source of infection is the urinary tract and can also cause catheter associated urinary tract infection (CAUTI).



There were 22 E coli bacteraemia infections in 2020/21 which is a decrease of one from the previous year. The PHE NW annual data for E coli hasn't been published yet, however in the last quarter of 2020/21 the Trust rate per 100,000 bed days was 41.7 and the NW average was 34.7; Southport & Formby CCG had the highest rate per 100,000 population in the NW, hence given this and in reviewing the chart below the Trust results are relatively very good – the increased rate of E-coli in the community is associated with Southport being unique by having the oldest population in the country which is matched only by Bournemouth.



Source: HCAI Data Capture System

Action: In addition to E coli there are other gram negative bacteria inhabiting the bowel that can cause UTIs including catheter associated UTIs. Hence, in addition to meeting the nutritional and cleanliness needs of patients we also need to consider the appropriateness of catheters and ensure they are properly managed. Improving the care of catheters and reducing their use or the number of days they're left in place was a project started, but stalled due to the Coronavirus pandemic, however this project has been reinstituted and has started with convening a project team which initially has updated the current pathway to be piloted on two wards. The objectives of this group is to engage with patients and staff so that catheters are used appropriately when needed and discontinued when not needed. The group will also consider and make recommendations on the use and content of catheter packs.

Klebsiella and Pseudomonas Bacteraemia

As mentioned above these are similar organisms to E coli and the sources of infection are also similar. Klebsiella bacteraemia is second only to E coli for the number of hospital bacteraemia of 19.

The Klebsiella rate per 100,000 bed days at 17.4 is just over the NW average of 16.3, however the Pseudomonas rate is 3.5 which is almost half the NW average of 6.4.

Similar to E coli, community attributed infections with these organisms are the highest in the NW in West Lancs and Southport & Formby CCGs, hence there is a greater opportunity for patients to bring these organisms in to the healthcare environment.

Actions: The actions by an large are the same as under E coli; the IPC team will continue to monitor and report to PHE the bacteraemia numbers.

CPE Screening

During this year 639 CPE admission screens were obtained from patients who were identified as being at increased risk of CPE colonisation, 4 were found to be positive, one of these patients was known previously to be positive, one was a community positive and the remaining two had been patients at the Royal Liverpool University hospital and the Walton Neuro.

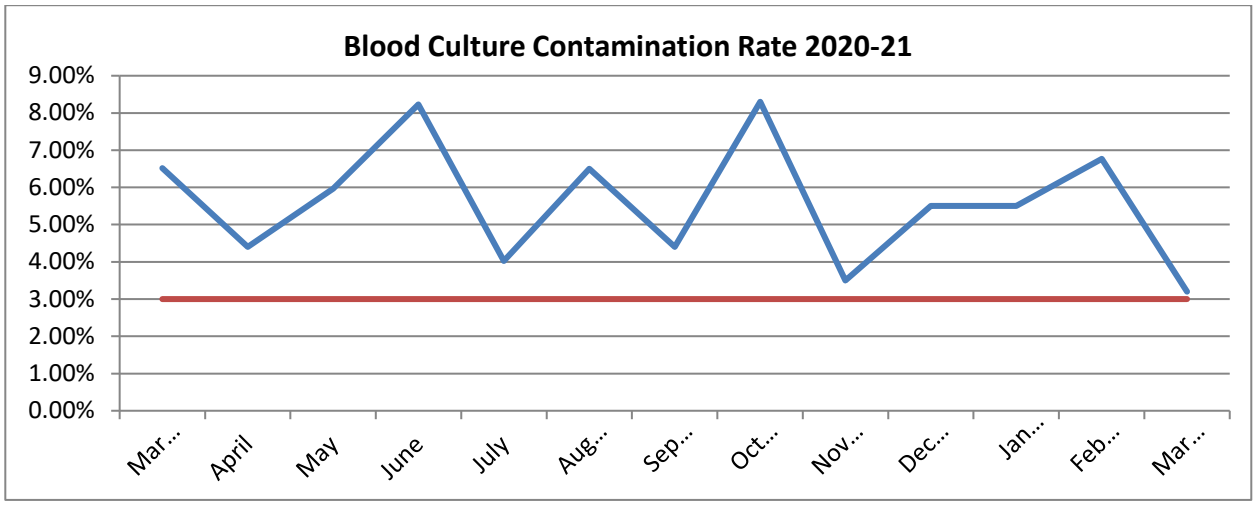
The overall low number of CPE cases all of which were not due to transmission within the Trust continues to identify the Trust as a low risk hospital for CPE.

Action: Continue to monitor for CPE colonisation and follow the PHE guidance. Consider screening amendments based on changing patterns. Work with partner organisations to identify potential cases and screen contacts.

Blood Culture Contamination

There will always been a potential for blood culture contamination, however this needs to be minimised through appropriate application of ANTT (Aseptic Non-touch Technique) otherwise patients will be inappropriately treated for infections they don't have which may lead to increased hospital stay or even risk of CDI.

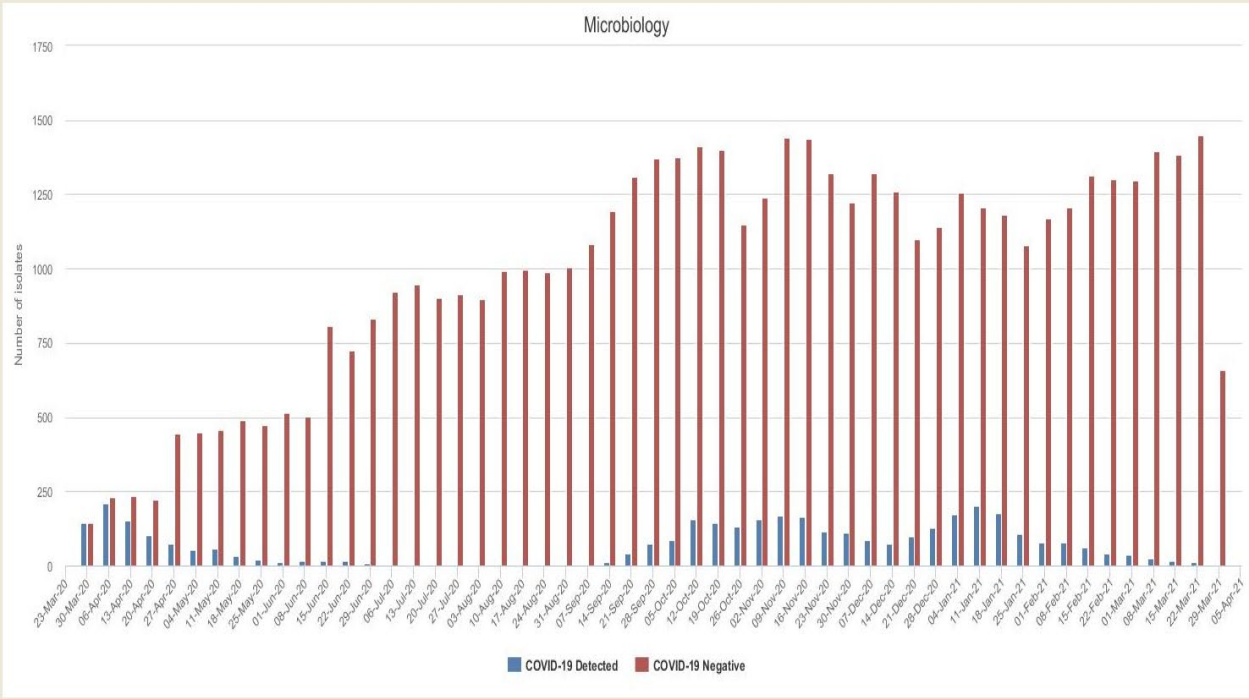
The chart below shows the red line at 3% which is considered to be the best achievable contamination rate. There have been times when the Trust has neared this figure, but then other times when this is far from this target. The times when the rate is low follows a concerted effort from the clinical scientist working with AED and the PEF (Practice Education Facilitator).



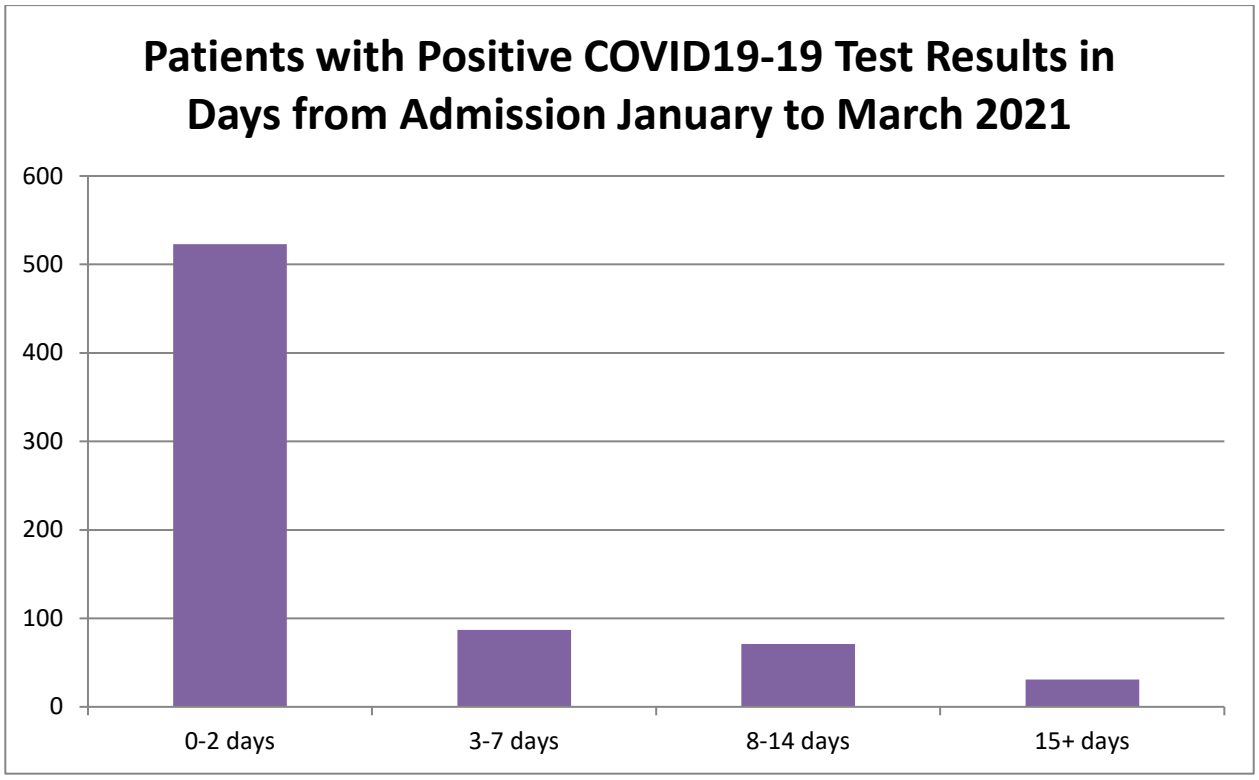
Action: The former AED PEF has now taken on a new role, however Urgent Care and Planned care CBUs have employed additional PEFs. The IPC has discussed the issues with the new PEFs who have committed to continuing the training and the work place practice assessments. The IPC team will continue to monitor with the Clinical Scientist and provide feedback to the staff.

COVID19-19

The chart below offers some indication of the scale of the effect of the COVID19-19 pandemic on the hospital purely by showing the scale of the weekly testing during 2020/21. For example in the week commencing 9/11/2020 over 1600 swabs were taken and 167 of these were positive. The graph also shows the transition from testing symptomatic patients in March 2020 to increasing the testing to all admissions, then admission to 5 day screening followed by admission, 3 day, 5 day and continuing 5 days screening thereafter.



The changes in testing protocols occurred due to the effects of asymptomatic carriage causing infections. The chart below shows the patients who tested positive from January – March 2021 and the number of days it took for them to become positive.



The significance of the above results is described by NHSEI so that a positive test 0-2 days post admission is considered community acquired, 3-7 days indeterminate healthcare associated, 8-14 days probable healthcare associated and 15 days and over definite healthcare associated.

The vast majority of patients testing positive were in the first group – patients who had acquired their infection in the community, the second significantly smaller group were patients who more than likely acquired their infection in the community, but may also have acquired their infection on admission to hospital, the 3rd group which continues to diminish in numbers more than likely acquired their infection in hospital and the last and smallest group almost certainly acquired infection in the hospital. The World Health Organisation (WHO) describes the incubation period as generally 4-6 days but can be up to 14 days.

In practice it is apparent that initial PCR COVID19 swabs may not detect the virus particularly if the patient is in the initial incubation period, this has led to patients with asymptomatic carriage transmitting the virus to others within the hospital setting and in some instances causing outbreaks. Most of the outbreaks involved single bays, however in some instances nearly whole wards were effected. No other outbreaks involving other organisms have occurred in the Trust.

As the pandemic has evolved so too has the national guidance and in addition the Trust has innovated in enhancing processes and using technology. Prior to the national guidance to screen patients on admission then at 3 and 5 days, the Trust had already put this into action and then continued screening negative patients at 5 day intervals because experience showed that inadvertent transmission could occur between patients even if their initial tests were negative.

The Trust went onto purchase Gama Redirooms; as an adjunct to isolation these fold out isolation rooms include a HEPA filter to pull air through the canopy and filter it (the Trust was the first in the world to use these in a clinical setting). Another near first was the installation of clear

isolation panels between bed spaces to limit the potential spread of the virus between asymptomatic patients.

The Trust also introduced enhanced cleaning processes and added to the domestic workforce NHSP cleaners that were trained and served alongside the permanent staff to cope with all the additional isolation cleans.

Actions: As already described there has been a plethora of actions completed in response to the pandemic, however one of the additional COVID19 risks includes providing sufficient ventilation through the wards and clinics. A ventilation group has been set up to initially assess the ventilation and then to make recommendations if enhancements are needed.

Gaps in Annual Programme and Actions

RCAs for Hospital Acquired C diff and Bacteraemia

Delays experienced in convening quorate RCAs.

Action: The IPCT, Risk and CBUs have used a PDSA methodology to enhance, streamline and make the IPC RCA process more effective, efficient and more meaningful wherein lessons can be learned and disseminated| **Due: Completed May 2021.**
Update: Engagement is much improved and more personal; there will no doubt be teething problems but so far things are working out.

MRSA Pathways

These are not always being completed.

Action: The IPC team are doing MRSA ward rounds and engaging with staff on completing the pathways. In addition the team is also placing yellow stickers in patient's case notes informing the doctors of new cases of MRSA; the team are also ensuring that ward Coordinators are aware of new MRSA cases. Urgent care HoN is engaging with Matrons and ward managers to encourage completion of the pathways| **Due: Completed May 2021.**
Update: Some good initial results; the IPC team will continue to monitor and engage with staff.

Isolating Patients with Diarrhoea

It has been identified that there is sometimes a delay in isolating patients with diarrhoea.

Action: IPC nurses meet with the bed managers 3 times a day and visit the wards typically first thing in the morning to identify any isolation needs. The isolation Redirooms are also available if side rooms are in short supply| **Due: Completed May 2021.**
Update: the increased interaction both with the wards and the bed managers is having the desired effect and Redirooms are being used as needed. IPC team to continue with work model and will monitor appropriate isolation.

IPC Training

Induction training is good but annual Mandatory training is just below target.

Action: HONs and Matrons have put out e-mails and requests for staff to complete their training| **Due: Completed in May 2021.**

Update: There has been a 5% improvement, but continued encouragement will be required to meet the standard.

IPC Link Workers

Unable to have face to face meetings/training due to COVID19 restrictions.

Action: Alternative means of interaction to be considered| **Due: July 2021.**

Update: Information has gone out through e-mails, phone calls and memo; to look into having socially distanced meeting in Clinical Education and include MSTeams.

IPC Staffing

Current staffing levels are good, however 6 month seconded placement finishes July 2021 and funding hasn't been designated for this to continue.

Action: DON and finance to identify additional ½ day funding to cover additional secondment followed by apprenticeship| **Update:** With some readjustment of staff within IPC team a half day has been arranged under the current staffing arrangements, however a further half day to make it a fulltime post is needed. IPC Matron to follow-up with DON and Finance and complete PAG form as soon as agreement made.

Appendices

Appendix 1

	Surveillance programme 2021-22	Lead	Frequency	Progress update
1.	Mandatory surveillance for MRSA bacteraemia	IPCT	Continuous	Reported Monthly
2.	Mandatory surveillance of *C. difficile*	IPCT	Continuous	Reported monthly
3	Participate in National mandatory surveillance of Orthopaedic SSI	Trauma Nurse	Continuous	Reported monthly
4	Mandatory surveillance for E coli, Klebsiella, and pseudomonas bacteraemia	IPCT	Continuous	Reported Monthly
5.	Continuous surveillance for MSSA bacteraemia	IPCT	Continuous	Reported monthly
6.	Alert organism and condition surveillance	IPCT	Daily	Completed daily; Review on ICNet
7.	All organism bacteraemia surveillance with infection rates by ward	IPCT	Continuous	Reported Monthly
8.	Enhanced Surveillance in Critical Care (Central Lines and Ventilator-associated pneumonia)	IPCT Critical Care Lead	Continuous	Reported monthly

9.	Inoculation incidents	Staff Health and Wellbeing	Continuous	Reported quarterly
10	Central line associated bacteraemia in non-critical care areas	IPCT	Continuous	Reported Monthly
11.	Invasive medical device prevalence for all wards	IPCT	Weekly	Reported monthly
12.	Quantitative assessment of commode cleanliness	IPCT	Weekly	Reported monthly
13.	Sepsis Mortality review	Executive Medical Director	Continuous	As required
14.	SSI Surveillance for Caesarean Sections (development of systems)	IPCT Head of Midwifery	Continuous	Reported monthly

Appendix 2

	Audit programme 2020-21	Lead	Frequency	Progress update
1.	Hand hygiene	IPCT Link practitioners	Monthly	Reported monthly
2.	MRSA screening compliance for elective & emergency admissions	IPCT	Monthly	Reported monthly
3.	Contamination of blood culture specimens	IPCT	Monthly	Reported monthly
4.	Compliance with MRSA Pathways	IPCT	Weekly	Reported monthly
5.	Compliance with C. difficile Pathways	IPCT	Weekly	Reported Monthly
6.	Hand gel availability	IPCT	Bi-weekly	Reported monthly
7.	Antibiotic audits	Antimicrobial Pharmacist	Monthly	Reported Monthly
9.	Compliance with cannula care plan	IPCT	6 monthly	Reported bi-annually
10.	Compliance with catheter care plan	IPCT	6 monthly	Reported bi-annually
11.	PPE audit	IPCT	monthly	Reported monthly
12.	IPC Ward and department IPC inspections	IPCT	Revolving programme	Reported monthly
13.	IPC Perfect ward audits	IPCT	Revolving programme	Reported monthly

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 JULY 2021**
Agenda Item	**TB122/21**	**FOI Exempt**	**NO**
Report Title	**ANNUAL HEALTH AND SAFETY REPORT**		
Executive Lead	Bridget Lees, Executive Director of Nursing, Midwifery and Therapies		
Lead Officer	John Buck, Head of Health, Safety, Security and Fire		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The report provides an update on the Trust's annual Health and Safety Programme which is based around standards that are designed to assist the Trust to achieve and maintain compliance with the health and safety legislation.

Executive Summary

This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health and Safety
- Security
- Fire

The Health and Safety Committee has met regularly to monitor the Trust's arrangements for Health, Safety, Fire and Security.

A key focus for this year has been on improving fire processes within the Trust following enforcement notices issued by Merseyside fire and Rescue Authority in early 2020. Significant progress has been made with the requirements. In particular, it's positive to note that:

- All fire risk assessments have been completed on the Southport site;
- Training for Fire has been reviewed and new training rolled out;
- Significant pieces of work have commenced in relation to fire compartmentation.

The Trust are awaiting further assessments from Merseyside Fire and Rescue Authority to assess whether any of the regulatory notices can be lifted.

In terms of the wider Health and Safety agenda:

- It's positive to note that there has been a decrease in Health and Safety Incidents compared to the previous 12 months;
- The Health and Safety Team have supported the Trust with COVID environmental risk assessments;
- A forward plan of audits and inspections is planned for this financial year and the outcomes will be reported in the next Annual Report.

Recommendation

The Board of Directors are asked to note the Trust's position in relation to Health, Safety, Fire and Security in the 2020/21 financial year.

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-centered leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
John Buck	Bridget Lees

Southport and Ormskirk Hospital NHS Trust

HEALTH and SAFETY, SECURITY and FIRE MANAGEMENT ANNUAL REPORT

1ST APRIL 2020 TO 31ST MARCH 2021

Mr J Buck
Head of Health, Safety, Security and Fire

Table of Contents

1. BRIEF/EXECUTIVE REPORT DETAILS

This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health, Safety and Welfare
- Security Management
- Fire Safety

The Trust's health and safety programme is based around standards that are designed to assist Trust to achieve and maintain compliance with the health and safety legislation.

Post	Current Officer	From 2020
Accountable Officer Health and Safety	Chief Executive	Chief Executive
Named Executive Director of Health and Safety	Executive Director of Nursing, Midwifery and Therapies Director of Infection Prevention and Control	Deputy Chief Executive and Director of Strategy
Security Management Director	Director of Finance	Director of Finance
Fire Safety	Executive Director of Nursing, Midwifery and Therapies	Deputy Chief Executive and Director of Strategy

Day to day responsibility for maintaining health and safety in the Trust is embedded into operational management arrangements of the Trust.

On the 25th February 2021 Merseyside Fire and Rescue Authority (MFRA) emailed the Chief Executive to the Trust of the withdrawal of the Fire Enforcement Notice (EN/MERS/466) which was served to the Trust to replace the original notice on the 26th March 2020.

The withdrawn Fire Enforcement Notice has been replaced with the following three separate Enforcement Notices

1. Fire Enforcement Notice (EN/MERS/503) relating to the Fire Detection and Alarm (Item number 1) – notice period 7 months (Wednesday 29th September 2021)
2. Enforcement Notice (EN/MERS/501) relating to Compartmentation (Item number 1) - notice period 7 months (Wednesday 29th September 2021)
3. Enforcement Notice (EN/MERS/502) – Notice period 4 months (Wednesday 26th June 2021)

   - Relating to Fire Risk Assessment (Item number 1)
   - Relating to Training Provision (Item number 2)
   - Relating to Evacuation (Item number 3)

The Trust is required to remedy the matters contained within the schedule within the three revised Fire Enforcement Notices. The current position of Fire Enforcement Notice (EN/MERS/502) is due to be completed on 26th June 2021 and the Trust has completed all actions relating to this Enforcement Notice and have provided MFRA with the documented evidence and are currently awaiting a response from the MFRA that they are satisfied with the Trust progress and are able to withdraw this notice as completed.

The two outstanding Fire Enforcement Notices (EN/MERS/501 relating to Fire Compartmentation and EN/MERS/503 relating to Fire Detection and Alarm System) are currently in progress and MFRA have indicated that they would give the trust two years to complete as long satisfactory progress has been made.

The Health, Safety, Security and Fire Team is in the process of producing a proposal to buy in staff training in restraint reduction and restrictive practice. In accordance with the Trust's SCOPE values and in line with the NHS Restraint Reduction Network, the aim of this training will be to up-skill some staff (based on risk levels) to ensure that they can manage challenging behaviors and only using restrictive practices in line with the Trust policy and the Mental Capacity Act (2005).

As one of the objectives detailed within the Forward Plan, a suitable external provider has now been identified to assist with the Trust's compliance to the Display Screen Equipment regulations and it is expected that the Health, Safety, Security and Fire Team will be given authorisation to procure the services of this company during Q2 of 2021. Several different training courses have been made available to Trust staff in a bid to achieve compliance in health, safety, security, and fire.

The team have been instrumental in ensuring change and compliance by leading and participating on a number of Task and Finish groups, producing COVID risk assessments and implementing control measures, carrying out inspections, undertaking investigations and consulting with enforcing agencies.

2. HEALTH, SAFETY SECURITY AND FIRE FORWARD PLAN 2020 – 2021

A comprehensive forward plan has been produced highlighting 28 aims, targets and objectives to be completed within a two-year plan, which include the following:

- COVID-19 Risk Assessments for all clinical and non-clinical areas
- Source a Health and Safety Management System to support the Trusts compliance requirements
- Fire Risk Assessments across the Trust
- Review the current Fire training
- Source funding for additional staffing levels
- Produce bespoke mandatory training packages
- Establish Health and Safety leads and Fire Wardens across the Trust
- Research a COSHH database system
- Lone working devices
- Produce a local incident investigation template
- Produce a Health and Safety expenditure plan
- Appoint risk assessor leads across the Trust
- Set up monthly meetings relating to CQC
- Produce a schedule of visits to external satellite premises

- Undertake joint Health and Safety inspections with trade union reps
- Audit Estates and Facilities projects which may relate to asbestos
- Review asbestos abatement works to ensure compliance
- Undertake Health and Safety inspections of clinical areas
- Undertake Health and Safety inspections of non-clinical areas
- Review and update Trust Health and Safety policies
- Review Estates and Facilities CAS alerts
- Produce quarterly incident reports
- Liaise with Health and Wellbeing regard work related incidents
- Produce RIDDOR reports
- Review the provision of DSE assessment
- Support CBU's with risk assessments
- Review the Trusts health, safety and fire training provision
- Setup topical Health and Safety awareness days for both sites

3. INTRODUCTION

During a difficult year due to the COVID-19 pandemic the Health and Safety team have supported the Trust with COVID-19 ward risk assessments for green, amber and red clinical zones and have also produced 217 COVID-19 risk assessments for both clinical and non-clinical environments and these assessments are reviewed and updated in line with HM Government Guidance as needed.
This report outlines the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding:

- Health and Safety
- Security Management
- Fire Safety

The Trust's health and safety programme is centred around standards that are designed to assist the Trust to achieve and maintain compliance with the various health and safety legislation.

The Health and Safety team staffing levels have now been improved with the appointment of a Senior Health and Safety Advisor, interim Senior Fire Advisor and Interim Health and Safety Coordinator; the two interim positions are in the process of being made permanent.

The Manual Handling Advisor role has now been relocated to fall under the Health and Safety team and this role is currently vacant and going through the necessary processes to be able to recruit to the role.

The approach of identifying gaps and risks associated with any of the Health and Safety and Fire Regulations benefits the Trust in gaining a wider knowledge of Health and Safety compliance. This is achieved by undertaking health and safety inspections and audits to identify any potential gaps within current Health, Safety and Fire provision relating to compliance.

The primary function of the Health, Safety Security and Fire team is to provide advice, support and assistance to all staff and managers in the Trust regarding health and safety, fire safety and security management.

Statutory accountability for health and safety in the Trust sits with the Chief Executive. Specific responsibilities are delegated to individual directors as follows:

Post	Current Officer	From 2020
Accountable Officer Health and Safety	Chief Executive	Chief Executive
Named Executive Director of Health and Safety	Director of Nursing, Midwifery, Therapies and Governance	Deputy Chief Executive and Director of Strategy
Security Management Director	Director of Finance	Director of Finance
Fire Safety	Executive Director of Nursing, Midwifery and Therapies	Deputy Chief Executive and Director of Strategy

Day to day responsibility for maintaining health and safety in the Trust is embedded into the operational management arrangements of the Trust.

4. STATUTORY FRAMEWORK

4.1 Primary UK Legislation

Within the United Kingdom, the primary legislation regarding health and safety at work is the Health and Safety at Work Act 1974. This Act imposes specific duties on all employers regarding ensuring the health safety and welfare of both employees and others who may be affected by the undertakings. The Act is supported by many supporting regulations that relate to specific elements of Health and Safety. Staff are the Trust's most important asset and should not be exposed to injury or made ill by work. The health, safety and welfare of staff directly contribute to organisational success and the Trust will fully implement the requirements of safety legislation which will also help to achieve the health and safety aspects of the NHS Resolution (formerly NHS Litigation Authority) and the standards of the Care Quality Commission (CQC).

5. HEALTH AND SAFETY SUPPORT

A requirement of the Management of Health and Safety at Work Regulations 1999 is that the Trust must have access to health and safety assistance. This was achieved as follows:

5.1 Health, Safety Security and Fire Team

The team comprises of specialist advisors in the field of health and safety, fire safety, and security management and was established in accordance with the Trust's statutory duties contained within the Management of Health and Safety at Work Regulations 1999. The regulations also require the Trust to ensure that the persons appointed are competent, through sufficient training, knowledge and experience, and that their competency is maintained.

The team works closely with colleagues from all areas of the Trust including, but not restricted to Infection Prevention and Control, Health and Wellbeing, Emergency Planning, Radiation Protection, Estates and Facilities and Education and Training Department. This co-working assists in facilitating a seamless approach across the Trust, thus avoiding conflicting advice and information.

5.2 Management of Health and Safety at Work Regulations 1999

The Management of Health and Safety at Work Regulations 1999 requires the Trust to employ competent person(s) in Health and Safety at Work. The Managers post is the lead "competent person", as required by the Management of Health and Safety at Work Regulations 1999.

6. WORKPLACE HEALTH AND SAFETY STANDARDS

6.1 Policies

The Trust has a suite of policies regarding Health and Safety at Work, and these are reviewed and monitored by the Health and Safety Committee and finally approved by the Policy Review Committee.

During the period 1st April 2020 to 31st March 2021, there were 5 policies scheduled for review and were agreed.

- Health and Safety Policy (RM 02)
- COSHH Policy (RM 14)
- Mercury Policy (RM 11)
- Fire Policy (RM 04)
- Smoke Free Policy (Corp 06)

7. CENTRAL ALERTING SYSTEM (CAS)

From the 1st April 2020 to 31st March 2021 the Trust received 3 Estates and Facilities Alerts (EFA/EFN's) which were applicable to this trust. These 3 alerts have been reviewed and actioned within the timeframe of the alert and a description of these alerts is highlighted below.

Reference	Issue Date	Description of Alert	Status	Progress	Deadline
NHSEI – 2020001	01/04/2020	Use of high flow Oxygen therapy devices (including wall CPAP and high flow face mask or nasal oxygen) during the Coronavirus epidemic	Issued	Action completed	N/A
NHSEI – 2020002	06/04/2020	Oxygen usage	Issued	Action completed	10/04/2020
NHSE/I-2020/003	19/11/2020	Covid-19 Response – Oxygen Supply and Fire Safety	Issued	Action completed	18/12/2020

7.1 Care Quality Commission (CQC)

The Health and Safety team have set up a monthly meeting with Assistant Director of Quality regarding compliance with CQC standards and a template has been produced covering the following compliance standards:

- Security of oxygen cylinders
- Security of hazardous chemicals/products (COSHH)
- Security of ward kitchen doors

This inspection is undertaken monthly by the Health and Safety team and the results from these inspections are shared with the various wards and departments and monitored through the Health and Safety Committee.

8. GOVERNANCE RELATING TO HEALTH AND SAFETY

8.1 Accountability

There is board level responsibility for Health and Safety, this role was initially carried out by the Deputy Chief Executive and Director of Strategy and from September 2020 the Executive Director of Nursing, Midwifery and Therapies Director of Infection Prevention and Control took over responsibility.

The roles and responsibilities in relation to health and safety at all levels of the Trust are detailed in the Trust's Health and Safety Policy.

8.2 Quality and Safety Committee

The Trust has established a Quality and Safety Committee, which is a subcommittee of the Trust Board. This committee receives regular reports regarding the work of the Health and Safety Committee.

8.3 Trust Health and Safety Committee

The Trust's Health and Safety Committee was established in accordance with the requirements of the Safety Representatives and Safety Committee Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996**.**

The Health and Safety Committee is a subcommittee of the Trust's Quality and Safety Committee, which in turn reports to Trust Board.

The Terms of Reference for the Health and Safety Committee requires representatives from; management, Staff Side Representatives and Specialist Advisors and these are reviewed annually.

During the period 1st April 2020 to 31st March 2021, the Trust's Health and Safety Committee met on the following dates:

Month	Date Time	Location
2020-2021		

April	Friday 24th 10:00 – 12:00 pm	Meeting Room Clinical Education SDGH
July	Friday 3rd 09:00 – 11:00 am	Boardroom CMO
September	Friday 4th 09:00 – 11:00am	Meeting room A
October	Friday 30th 09:00 – 11:00am	Meeting Room A
December	Friday 11th 09:00 – 11:00am	Teams
February	Friday 26th 09:00 – 11:00am	Teams

The Health and Safety Committee meeting have standing agenda items for Health, Safety, Security and Fire issues as highlighted within the list below, this list is not an exhausted list.

- Accident, incident statistics, progress with completion of audits and progress against training requirements.
- RIDDOR reportable incidents to the HSE
- Central Alert System (CAS) Alerts
- Fire Activation Alerts which have occurred at the Trust
- Any issues that require escalation to the Quality and Safety Committee are identified at the Health and Safety Committee.
- Any relevant Policies which may require review
- Quarterly reports covering Health, Safety, Security and Fire
- Health and Safety reports relating to Health, Safety, Security and Fire
- Enforcement Notices

Items requiring escalation are documented on the AAA report and disseminated to the Quality and Safety Committee.

The meetings of the Health and Safety Committee is to monitor and review all aspects of health, safety, fire and security and provide assurance to the Trust that they are complying with statutory requirements in relation to consultation with staff side health and safety representatives.

9. JOINT WORKING WITH OTHER EMPLOYERS

The Management of Health and Safety at Work Regulations 1999 requires the Trust to co-operate with other employers who have employees working on Trust sites.

The staff concerned who are employed in the Pathology Service, which is managed by St Helens and Knowsley Hospitals NHS Trust.

9.1 Contractors

The Health Safety Team support the Trust's Capital Project Manager(s) and Estates Department to ensure the safe completion of capital developments on Trust property.

This practice ensures information is reviewed and shared with other parties and that awareness is raised regarding specific risks that may affect the operations of either the Trust and/or the third party.

9.2 Safety Representatives

During the last year Staff Health and Safety Representatives attended the Trust Health and Safety Committee. The team have ensured that whenever available, Staff Health and Safety Representatives participated in Health and Safety audits, around the Trust. The joint approach towards completion of health and safety audits will be continued, by the Health and Safety Team during the current year.

9.3 Health and Safety Risk Assessments

All risks relating to health and safety are managed in line with the Trust's processes for risk assessment and risk registers.

All Health and Safety Risks should be recorded using the Risk Assessment Template which is available within the appendices of the Risk Assessment and Risk Registers Policy (RM 26).

All risks relating to health and safety are reviewed in line with the frequency identified in the Trust's Risk Management Strategy and are reported to and monitored as part of the relevant governance frameworks. All risk assessments should be reviewed and approved by the Corporate or Clinical CBU'S prior to being uploaded onto the Risk Register.

The Health and Safety Team maintain an overview of all health and safety related risks, and provide advice, support and assistance to managers and staff regarding assessment and ongoing management of risks.

10. HEALTH AND SAFETY TRAINING

Due to the COVID-19 pandemic all health and safety training was suspended with the exclusion of face to face fire training for managers and fire wardens and e-learning.

The training activity that was completed during the period 1st April 2020 to 31st April 2021 was as identified below with the %compliance highlighted.

The areas of training which relate to Health and Safety are as follows:

Course Type	Require competence	Meet requirement	Does not meet requirement	% of compliance
Local Fire	3053	2030	1023	66.49%

Fire Safety (e-learning)	3053	2457	596	80.48%
Fire Managers/ Wardens	Class started Jan 2021	28 completions	TNA being finalised	-
Fire Response Team	Classes to begin 26th May 2021	TNA being finalised	TNA being finalised	TNA being finalised
H,S & Welfare	3053	2737	316	89.65%
Conflict Resolution	2453	1751	702	71.38%

In order to plan training delivery, the Health Safety Security and Fire team used information supplied by the Education and Training team, which identified the likely demand for each subject area throughout the year.

In March 2020, all Trust training was suspended due to the COVID-19 pandemic. Some training is now being delivered in an e-learning format.

All Fire training has been reviewed and updated in line with the requirements of the enforcement notice from Merseyside Fire and Rescue Authority and updated training for Fire Managers/Wardens and Fire Response Team is in place.

11. HEALTH AND SAFETY AUDITS

The Health and Safety Team are in the process of producing an inspection and audit template to undertake inspections and audits throughout the year and dates have been schedule for quarter 3.

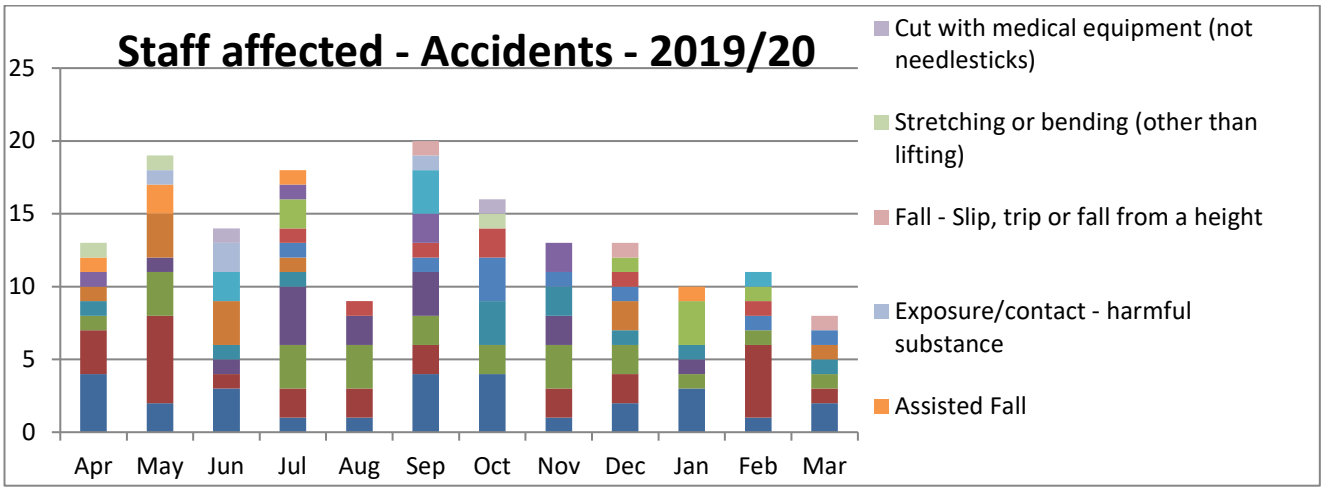
12. HEALTH AND SAFETY INCIDENTS

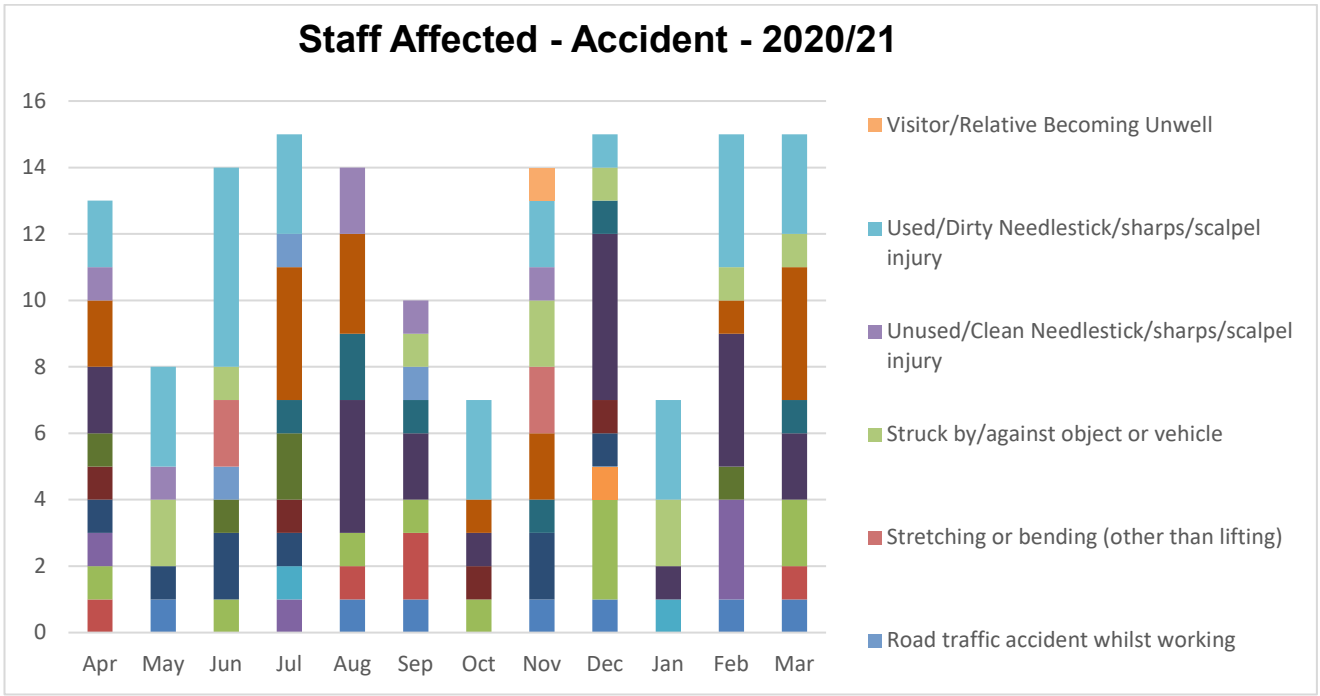
During the period 1st April 2020 to 31st March 2021, a total of 462 health and safety incidents were reported in the Trust. This was a decrease from the previous year's total of 742.

These incidents include incidents that affected staff, patients and visitors.

12.1 Staff Incidents 2020/21

During this period there were a total of 147 accidents which involved Trust employees as identified by the categories by month within the table below.





The 5 most common causes of these incidents were as follows:

Category	2019/20	2020/21
Used/Dirty Needlestick/sharps/scalpel injury	28	30
Fall – Slip, trip or fall on the same level	26	21
Lifting or moving a patient or other person	22	17
Collision with an object or person – no fall	14	10
Lifting or moving an object or a load	11	17

During the period 1st April 2020 to 31st March 2021; of the top 5 reportable incidents there has been a slight decrease over this period compared to the previous year. All incidents were reviewed to identify possible preventative action to prevent further incidents.

The Health Safety Security and Fire Team review staff incidents, in order to ensure that satisfactory action is taken to prevent further incidents and all required evidence is collated.

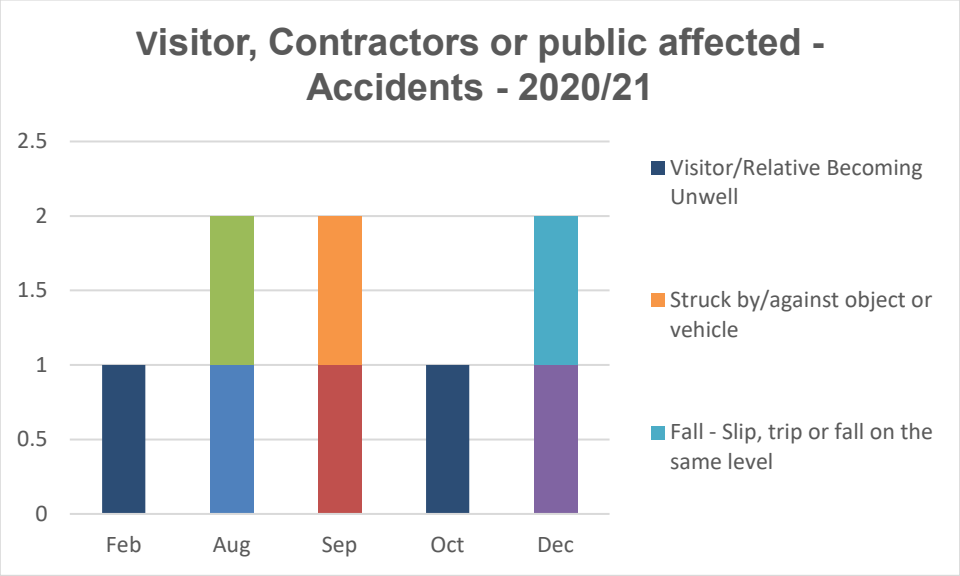
The table above highlights the number of incidents for both 2019/20 and 2020/2021. Used / Dirty Needle Stick / Sharps / Scalpel Injury still remains the top highest reported incident by category. The Trust has invested in the use of safety needles, for staff which have protective covers fitted that should be fitted to the needle after use and work is continuing to raise awareness with staff to ensure safe operation. This is monitored through Occupation Health and staff are supported where incidents have occurred.

12.2 Health and Safety Incidents which affected Visitors, Contractors and the Pubic

There were low numbers of incidents involving visitors, contractors and the public. Each case is reviewed by the Health and Safety Team and investigated where necessary.

The overall trend for incident which affected Visitors, Contractors and the Public is as follows:

Visitors, contractors or Public affected – Accidents – 2020/21														
Sub Category	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**	**%**
Contact with hot or cold material					1								**1**	**12.5**
Collision with an object or person – no fall					1						1		**2**	**25**
Visitor/Relative becoming unwell							1						**1**	**25**
Struck by/against object or vehicle						1							**1**	**12.5**
Fall – Slip, trip or fall on the same level									1				**1**	**12.5**
Fall – Slip, trip or fall due to collision with an object or person (eg: furniture and fittings)									1				**1**	**12.5**
Contact with electricity						1							**1**	**12.5**
Grand Total	**0**	**0**	**0**	**0**	**2**	**2**	**1**	**0**	**2**	**0**	**1**	**0**	**1**	**8**



13. REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS (RIDDOR) 2013 – REPORTABLE INCIDENTS

During the period 1st April 2019 to 31st March 2020, the Trust had 14 incidents and for the same period of 2020 to 2021 the Trust had 14 incidents reported to the Health and Safety Department and these were subsequently reported to the Health and Safety Executive as required by RIDDOR. (See table below).

These RIDDOR incidents have been broken down by category as highlighted in the tables below 2020/2021.

These RIDDOR incidents have been broken down by category as highlighted in the tables below 2019/2020.

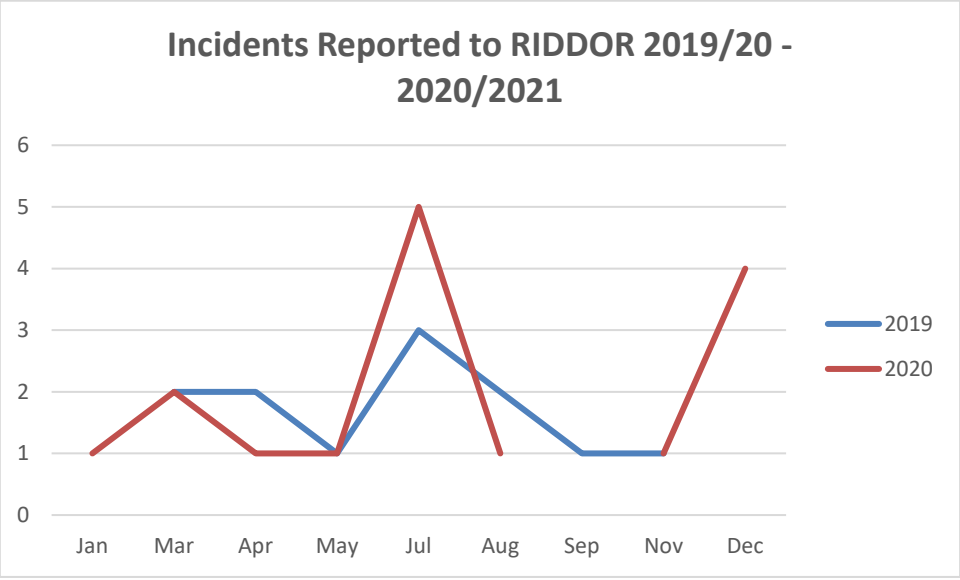
RIDDOR Accident Types 2019/20												
	2019									2020		
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Slipped, tripped or fell on the same level				2	3		1	1				
Injured while handling, lifting or carrying	1		1		2							1
Hit something fixed or stationary	1											
Physically assaulted by a person											1	
Grand Total	**2**	**0**	**1**	**2**	**5**	**0**	**1**	**1**	**0**	**0**	**1**	**1**

RIDDOR Accident Types 2020/2021												
	2020									2021		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Collision with an object or person – no fall									1			

Fall – slip, trip or fall due to collision with an object or person (eg: furniture and fittings)				1								
Fall – slip, trip or fall on the same level									3			1
Lifting or moving a patient or other person				1								
Lifting or moving an object or load				2								
Physical abuse/violence – (patient on staff)					1							
Stretching or bending other than lifting)								1				
Struck by/against object or vehicle		1										
Unsafe environment	1			1								
Grand Total	**1**	**1**	**0**	**5**	**1**	**0**	**0**	**1**	**4**	**0**	**0**	**1**

The table below highlights the total numbers for the 2 years which shows the same number were reported in the previous year.

RIDDOR													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**
2019/20	2	0	1	2	5	0	1	1	0	0	1	1	**14**
2020/21	1	1	0	5	1	0	0	1	4	0	0	1	**14**



All reportable incidents are fully investigated by the Health and Safety Team and a Health and Safety investigation report and action plan is produced.

13.1 Health And Safety Executive Interventions

During the period 1st April 2020 to 31st March 2021, there were no interventions carried out in the Trust by the Health and Safety Executive.

13.2 COVID-19 Environmental Risk Assessment

The Trust is continuing to undertake COVID-19 risk assessments throughout the Trust and reviewing and amending them following recommendations by HM Government COVID-19 guidance. These are monitored through the Monitoring Group which is Silver Command.

An example of the kind of actions that have been implemented as a result include screens on reception desks, tills, and workstations, improved spacing of desks, additional hand sanitisers stations, one-way systems, improved monitoring of cleaning supplies and equipment and increased cleaning of areas.

13.3 Slips and Trips

The Trust has a Falls Prevention Policy in place, which addresses patient specific and general falls prevention.

Falls prevention utilises risk assessments that are either specific to individual patients or relate to the environment. This is a requirement of the Management of Health and Safety at and Work Regulations 1999.

Falls involving Trust staff were covered in reports to the Trust's Health and Safety Committee that were prepared by the Health and Safety team.

All falls incidents that were reviewed on the Datix Incident Reporting system were reviewed by the Health and Safety team for non-clinical areas, to ensure all possible actions were taken to prevent a potential reoccurrence and also provide lessons learnt.

13.4 Manual Handling

The Trust is currently in the process of appointing a manual handling advisor following the retirement of the previous Manual Handling Advisor.

The Trust has a Manual Handling Policy in place, which identifies how the risk of harm from manual handling is controlled, in line with the requirements of the Manual Handling Operations Regulations 1999.

The Trust has in place processes for assessing the manual handling requirements of individual patients, which is a key part of the clinical management of each patient.

The Trust has maintained the existing provision of manual handling aids, which are provided to reduce the risk of harm to staff and patients. The Manual Handling role has recently transitioned under the remit of the Health and Safety Team as the Manual Handling Regulations fall under the umbrella of health and safety Legislation.

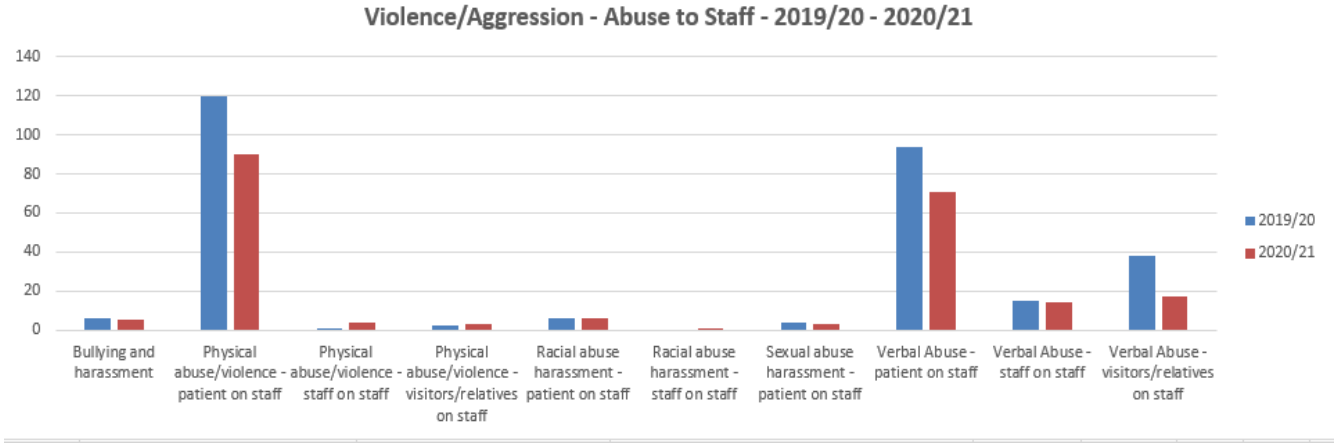
13.5 Violence and Aggression

The Trust has an established Policy for the Management of Violence and Aggression. The risk of violence has been controlled using risk assessment methodologies, which relate to the general risk of violence or

patient specific risks. This allows the Trust to meet its obligations from the Management of Health and Safety at Work Regulations 1999.

During the period 1st April 2020 to 31st March 2021 there were 214 incidents of violence/aggression/abuse to staff, which is a decrease of 72 from the previous year's figure of 286 as highlighted below.

Violence and Aggression	2019/20	2020/21
Bullying and harassment	6	5
Physical abuse/violence – patient on staff	120	90
Physical abuse/violence - staff on staff	1	4
Physical abuse/violence - visitors/relatives on staff	2	3
Racial abuse harassment - patient on staff	6	6
Racial abuse harassment - staff on staff	0	1
Sexual abuse harassment - patient on staff	4	3
Verbal Abuse - patient on staff	94	71
Verbal Abuse - staff on staff	15	14
Verbal Abuse - visitors/relatives on staff	38	17
Grand Total	**286**	**214**



13.6 Security Training

The Trust's training provision regarding violence and aggression has focussed on Conflict Resolution, during the period 1St April 2020 to 31st March 2021 the Trust delivered training to staff and is currently at 71.38% compliant; this is a decrease in compliance from the previous year 2019 to 2020 which was at 91% this is a reduction of 22.87%, which in the main is due to all training provision throughout the Trust being suspended for a period of time due to COVID-19.

13.7 Lone Working

Lone working is risk managed under the terms of the Management of Health and Safety at Work Regulations 1999. The Trust has an established Policy for the Management of Lone Working. This is based on use of risk assessment to identify and control risks. Lone work scenarios are recorded on the Trust risk

register and are reviewed as part of operational risk management and health and safety audits. The risks regarding lone working are monitored by the Health Safety Security and Fire Team.

13.8 Stress

While there is no specific law relating to Stress, the Trust is required to assess and manage this risk as per regulation 5 of the Management of Health and Safety at Work Regulations 1999. To achieve this, a Stress risk assessment methodology is contained in the Trust's Policy for the Management of Occupational Stress. Stress has been managed as part of the Trust's Health and Well Being arrangements.

Stress risk assessments were managed as part of the Trust's Governance processes by the HR Department.

13.9 Control of Substance Hazardous Health (COSHH)

The Trust has a Policy in place for control of substances hazardous to Health (COSHH) which has been reviewed and approved. The policy which is based on the requirements of the Control of Substances Hazardous to Health Regulations 2002 and requires all departments to maintain an inventory of hazardous substances, and to carry out COSHH risk assessments for those substances.

The Trust provides health surveillance to groups of staff who are exposed to substances that may have an adverse effect on their health and safety, this process has been delivered by the Health and Well Being Service.

13.10 Management of Sharps

There are specific requirements regarding sharps that arise from the Health and Safety (Sharp Instruments in Health Care) Regulations 2013. This requires that "safer" sharp instruments should be used in healthcare organisations.

The Trust has been using sharp instruments that are designed to be "safer", due to the use of protective covers that encase the needle following use. The use of these safer sharps is monitored as it has been noted that incidents are continuing to occur in the Trust. There have been occasional incident reports which suggested that the covers were not effective. As a result of investigations, further training was provided to staff regarding the use of the safety covers.

The Health Safety Security and Fire Team review reports of all sharp's incidents, in the Trust, and will continue to monitor.

13.11 Work Equipment

All work equipment that is purchased by the Trust, must be suitable for its intended use. The Trust has processes in place to ensure that high risk equipment such as medical devices is fit for purpose and is reviewed by key staff such as the infection control team. This allowed the Trust to demonstrate that it is following the requirements of the Provision and Use of Work Equipment Regulations (PUWER) 1998.

13.12 Display Screen Equipment

The Trust has a policy for Display Screen Equipment, which identifies standards for all elements of workstations. The policy also provides the process that can be used to carry out workstation assessments. This allows the Trust to discharge its duties under the Health and Safety (Display Screen Equipment) Regulations 1992.

The Health Safety Security and Fire Team monitor the completion of Display Screen Equipment workstation assessments, as part of health and safety audits that are carried out in the Trust.

Compliance with workstation safety will continue to be monitored as part of Health and Safety audits carried out by the Health and Safety Department and manual Handling Advisor.

Due to the retirement of the Manual Handling Advisor whose role and responsibility is to undertake DSE risk assessments, this is currently being managed for an interim period by the Health and Safety team whilst awaiting the recruitment of the Manual Handling Advisor.

13.13 Legionella

The management of the risk posed by legionella is covered by the requirements of the Control of Substances Hazardous to Health Regulations 2002.

This requires the Trust to carry out risk assessments of water supply systems, to identify and address risks. This work is carried out by an external agency, and the findings are used to identify requirements for works, to reduce risk in the water infrastructure.

The findings of legionella risk assessments are over seen by the Trust's Water Safety Committee. This is managed by the Facilities Management Team, who have ensured that testing for legionella is carried out in the Trust.

The Health Safety Security and Fire Team is represented at the Water Safety Committee and will continue to play an active role in ensuring that all possible steps are taken to reduce the risk of legionella.

13.14 Asbestos

The Trust's arrangements for management of asbestos are detailed in the Control of Asbestos Policy, the content of which sets out the Trust's arrangements for complying with the Control of Asbestos Regulations 2012.

The Trust maintains registers of all asbestos in the Estates Department(s) on each hospital site. In order to inform the content of the register surveys of the Trust estate have been carried out by competent surveyors.

The Health Safety Security and Fire Team is consulted regarding capital projects that could involve disturbing encased asbestos; a scheme that is currently being implemented relates to improvement of fire

compartmentation at SDGH. The planning of this scheme involved sharing with the contractor's asbestos surveys for affected areas of the site.

13.15 Electricity

Electrical safety is covered by the Health and Safety at Work Act, Management of Health and Safety at Work Regulations and Electricity at Works Regulations.

The maintenance and testing of all electrical systems has been carried out by the Facilities Management Teams.

The Estates Department on both sites have ensured that portable appliance testing (PAT) has been tested during health and safety audits. All equipment checked was found to have in date testing.

13.16 Management of Contractors

The activities of contractors are subject to controls that arise from the Management of Health and Safety at Work Regulations and the Construction, Design and Management Regulations (CDM) 2007.

Contractors who are deployed on Trust property for the purposes of Capital Projects and maintenance are controlled by the Facilities Department. When projects fall under the remit of the CDM Regulations, the Facilities Management Team has appointed competent external advisors, who have registered the schemes with the Health and Safety Executive.

For schemes carried out during the last year, the Health and Safety team have maintained contact with contactors and external advisors appointed by the Trust. This has ensured that the Trust can be assured regarding the safe delivery of projects.

13.17 Workplace Temperature

Maintaining Thermal Comfort in the workplace is a requirement of the Workplace (Health, Safety and Welfare) Regulations 1992**.** The ability for staff to maintain thermal comfort, using portable equipment such as fans is checked during health and safety audits etc.

The impact of and the extremes of weather are considered as part of the Trust Emergency Planning arrangements, which are overseen by the Resilience Group. The Physical Risk Manager is a member of the Resilience Group. The Health and Safety team have worked with staff Health and Safety representatives to develop a standard operating procedure for thermal Comfort. This will provide a structured approach to management of thermal comfort in the Trust.

13.18 First Aid

First Aid provision is covered by the Health and Safety (First Aid) Regulation 1981. This requires the Trust to have arrangements in place for staff to access first aid, it also indicates that qualified Doctors and Nurses can administer first Aid.

During the last year, the Health Safety Security and Fire Team in liaison with the Clinical business Units have reviewed provision in the Trust.

First Aid arrangements have been monitored by the Health and Safety team as part of health and safety audits, this process will continue during the current year.

13.19 New and Expectant Mothers

The Trust has legal obligations arising from the Management of Health and Safety at Work Regulations 1999, towards any employees who are expectant of new mothers. This requires the Trust to carry out an assessment of risks, in relation to the employee's normal employment and to take action to reduce risks.

This has been carried out by departmental managers using a methodology the Health Safety Security and Fire Team has previously developed to meet the requirement to assess risk in relation to new / expectant mothers.

14. SECURITY MANAGEMENT

During the period of 1st April 2020 to 31st March 21 the Trust recorded 145 security incidents via DATIX which is an increase of 1 compared to the previous year 2019/2020.

Security Incidents													
Period	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2019/20	16	13	17	16	8	13	11	12	11	10	12	5	**144**
2020/21	9	12	10	7	16	17	11	14	11	11	15	15	**145**

The table below highlights the monthly incidents by sub-category.

Security Incidents by Sub-Category 2020/21														
Security by Sub-Category	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Grand Total**	**%**
Assistance calls	0	0	0	1	1	0	0	0	0	0	0	0	**2**	**1.3**
Criminal damage/vandalism to hospital property	1	0	1	0	2	0	1	0	1	1	0	0	**7**	**4.8**
Damage to vehicle	1	0	0	0	1	0	0	0	0	0	0	0	**2**	**1.3**
Intruder alarm	0	0	0	0	1	0	0	0	2	0	1	0	**4**	**2.7**
Intrusion/trespass	1	0	0	0	1	1	0	1	0	0	2	1	**7**	**4.8**
Keys lost / unaccounted for	0	1	0	0	0	2	0	0	1	0	1	0	**5**	**3.4**
Loss/Theft - personal property	1	5	2	2	3	5	4	7	5	8	7	10	**59**	**40.6**
Loss/Theft - trust property	2	0	0	0	0	0	1	3	1	0	0	0	**7**	**4.8**
Lost SMART card/ID Badge	0	0	0	1	0	0	0	0	0	1	0	0	**2**	**1.3**
Public disorder	0	1	0	1	0	0	1	1	1	0	1	1	**7**	**4.8**

System failures	1	1	4	1	5	1	2	1	0	0	0	0	**16**	**11**
Unlawful use of controlled substances in hospital	0	1	0	0	1	3	1	0	0	0	0	0	**6**	**4.1**
Unsecured areas, doors, windows	2	3	3	1	0	5	1	1	1	1	3	0	**21**	**14.4**
Grand Total	**9**	**12**	**10**	**7**	**15**	**17**	**11**	**14**	**12**	**11**	**15**	**12**	**145**	

14.1 Security Management Function

The local Security Management Specialist's (LSMS) overall objective in the las reporting year has been to deliver and environment that is safe and secure concentrating on the Four Key Sections of NHS Protects' "Standards for providers"

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

14.2 Trust Security Guard Service

In April 2016, the Trust introduced a Security Service, to act as a deterrent to offenders and provide support to staff involved in managing violent patients during high-risk periods. The service provides 24-hour cover 7 days a week at SDGH and 7 days a week between the hours of 4.00 PM to 12.00 AM the Health Safety Security and Fire Team continue to work closely with the service.

14.3 Lockdown

In order to effectively manage on site emergencies, it may be necessary to implement a partial / full lock down of an entire hospital site. In order to achieve this, the access control infra-structure has now been enhanced to facilitate automatic lock down of all doors on the access control system on the Southport site and a manual lockdown on the Ormskirk site as an automatic lock down is not available.

Facilities Team and the Emergency Preparedness Manager have prepared a policy for Lockdown, which was agreed by the Trust's Resilience Group.

14.4 Security Audits

Routine security checks are undertaken on a daily basis to maintain ongoing security.

Due to a lack of resources security audits were not undertaken for the period 1st April 2020 to 31st March 2021.

14.5 Future Plans

During the year the Health, Safety, Security and Fire team have continued to work with our staff side colleagues to support the management of security risks in the Trust. When a new structure is in place the security audit regime will be commenced.

14.6 Assurance

Future audits and assessments will provide the Trust with assurance that standards of security are being maintained at a satisfactory level. Where there are gaps in standards of compliance, action plans have been formulated to address issues.

14.7 Managing Security Risks

Security risks in the Trust are managed in line with the processes used to manage all other risks this ensures that security risks are managed as part of the governance arrangements of each of the Clinical Business Units.

The Health Safety Security and Fire Team have maintained an overview of all security risks that are recorded on the risk register and will continue to challenge the management of security risks.

14.8 Loss / Theft – Personal Property

The Trust policy, Care of Patient Property (Clinical Corporate 72) includes a flow chart to enable staff to gain a quick reference which should lead to an increase in compliance of the policy. The Trust website has been updated to encourage patients not to bring in unnecessary personal possessions and to leave items of high monetary value at home or with family. It is perceived that some in-patients maybe reluctant to hand over cash amounts as currently, the Trust policy states that in-patients should be advised that if their stay is expected to be longer than 5 days, and they have more than £100 cash then this will be returned in the form of a cheque.

14.9 Violence and Aggression Incidents

Where the incident is related to malicious behaviour and a criminal breach the police are then involved and they assess if charges are appropriate.

14.10 CCTV and Security Systems

The Trust uses a variety of security systems including the access to the Security Guard teams to assist with the provision of a pro-security culture amongst staff, professionals and the public – to engender a culture where the responsibility for security is accepted by all.

The systems used to protect patients, staff, professionals, property and assets are closed circuit TV, access control, intruder alarms, personal assistance alarm systems and mobile telephone systems.

The Health Safety Security and Fire Team use the CCTV to assist in the management and investigation of incidents on behalf of the Trust and any Police enquiries received.

14.11 External Warning Notices Received

The Trust receives external warnings of potential threats from a variety of organisations. The warnings are mostly for the protection of staff against violent individuals but can include threats such as organised theft or threats to damage property. These warnings can be received from NHS Protect, NHS England and the Police.

Between 01/04/2020 and 31/03/2021 the Trust had 6 NHS Protect Alerts.

15. FIRE SAFETY

Following the previous Fire Enforcement Notice served on the Trust on the 26th March 2020, Merseyside Fire and Rescue Authority have now withdrawn this notice.

On the 25th February 2021 Merseyside Fire and Rescue Authority emailed the Chief Executive regarding the withdrawal of the Fire Enforcement Notice (EN/MERS/466) which was served to the Trust to replace the original notice on the 26th March 2020.

The withdrawn Fire Enforcement Notice has now been replaced with the following three separate Enforcement Notices

1 Fire Enforcement Notice (EN/MERS/503) relating to the Fire Detection and Alarm (Item number 1) – notice period 7 months (Wednesday 29th September 2021)

2 Enforcement Notice (EN/MERS/501) relating to Compartmentation (Item number 1) - notice period 7 months (Wednesday 29th September 2021)

3 Enforcement Notice (EN/MERS/502) – Notice period 4 months (Wednesday 26th June 2021)
- Relating to Fire Risk Assessment (Item number 1)
- Relating to Training Provision (Item number 2)
- Relating to Evacuation (Item number 3)

The Trust Head of Health, Safety, Security and Fire has produced a revised Fire Enforcement Notice Action Plan to incorporate all the joint actions from all three Fire Enforcement Notices as highlighted above. The Trust as set up a Task and Finish Group to review and monitor the Trust actions against the three separate Fire Enforcement Notices. Also, the Trust Fire Enforcement Notice action plan is reviewed and monitored by the Health and Safety Committee as a standing agenda item for all scheduled meetings. All three Enforcement Notices are currently progressing within the agreed timescale set out within the notices and one of the three Enforcement Notices (EN/MERS/502) all actions relating to this notice have been completed and is awaiting confirmation from the Merseyside Fire and Rescue Authority that the actions completed by the Trust meet the requirements of the Enforcement Notice.

15.1 Fire Risk Assessments

All fire risk assessments on the Southport site have now been completed in line with the requirements of the Enforcement Notice actions. Work has begun to start risk assessments on the Ormskirk site.

15.2 Fire Evacuation Exercises

During the period 1st April 2020 to 31st March 2021, the Health Safety Security and Fire Team have no record of any fire evacuation drills of non-patient areas of the Trust taking place.

From April 2021 a schedule of fire evacuation drills for non-patient areas has been commenced. Walk–through fire evacuation drills are schedule on a yearly basis for all staff in patient access areas, led by the Ward Managers. The Interim Senior Fire Advisor will liaise with all ward managers to assist these drills.

15.3 Fire Safety Training

Fire Safety Training is delivered in accordance with the Fire Safety Policy RM04

During the period 1st April 2020 to 31st March 2021 the following training was delivered.

Course Type	Require competence	Meet requirement	Does not meet requirement	% of compliance
Local Fire	3053	2030	1023	66.49%
Fire Safety (e-learning)	3053	2457	596	80.48%
Fire Managers/ Wardens	Class started Jan 2021	28 completions	TNA being finalised	-
Fire Response Team	Classes to begin 26th May 2021	TNA being finalised	TNA being finalised	TNA being finalised
H,S & Welfare	3053	2737	316	89.65%

Note: During the peak of the COVID-19 pandemic practical fire safety training was suspended. Practical fire training for managers and fire wardens recommenced in January 2021.

15.4 Fire Safety Incidents

During the period 1st April 2020 - 31st March 2021, 26 fire safety related incidents were reported on Datix. (25 on the Southport site and 1 at the Ormskirk site). This represented a reduction from the previous year of 44% when 47 fire safety incidents were reported.

Within the 12-month reporting period there had been a significant reduction in alarm activations by patients or public from 8 to 3 (63% reduction) and malicious from 3 to 0.

Across the Trust all of the incidents reported from fire alarm activations resulted in only two actual fires being recorded, this is a step back from the previous year when none reported were actual fires. This also resulted in a decrease in the number of unwanted fire signals from 7 to 1.

Annual Report: 01/04/2019 – 31/03/2020			Annual Report: 01/04/2020 – 31/03/2021		
Site	**False Alarm Category**	**Number**	**False Alarm Category**	**Number**	**% Increase + or Decrease - on previous year**
SFDGH	Accidental damage	2	Accidental damage	1	100%
	Activated by patient or public	8	Activated by patient or public	3	75%
	Environmental effect – cooking fumes	6	Environmental effect – cooking fumes	9	33%
	Environmental effect – other	10	Environmental effect – other	8	20%
	Environmental effect - smoking	1	Environmental effect - smoking	0	100%
	Good intent	1	Good intent	0	100%
	Malicious	3	Malicious	0	100%
	Management procedures not complied with	1	Management procedures not complied with	2	100%
	Systems fault – design	4	Systems fault – design	0	100%
	Unknown	5	Unknown	1	80%
	Total	**34**	**Total**	**24**	**20.6%**
	Actual Fires	**Number**	**Actual Fires**	**Number**	
	Malicious	**1**		**0**	100%
	Equipment Failure - Electrical	**0**		**1**	100%
	Total	**1**	**Total**	**1**	**No Change**
ODGH	Environmental effect other	2	Environmental effect other	0	100%
	Unknown	1	Unknown	0	100%
	System Fault Design	1	Alarm activated by patient or public	0	100%
	Total	**4**	**Total**	**6**	**50%**
	Actual Fires	**Number**	**Actual Fires**	**Number**	
	Unknown	0	Unknown	1	100%
	Total	**3**	**Total**	**1**	**66%**
	Trust Total	**44**	**Trust Total**	**26**	**6.8%**

15.5 Future Plans

The main fire safety priority for the Interim Senior Fire Safety Adviser over the next 12 months is to ensure compliance with the requirements of the Enforcement Notice within the agreed timeframes specified by the Enforcing Authority and to carry out works to ensure that the fire safety on the Ormskirk site also meets the same required standards.

To achieve compliance with the Enforcement Notice, the Trust will need to embed a robust fire safety management structure, systems and culture across the Trust sites and ensure that the Trust's fire safety provisions are monitored and maintained during future Fire Safety Audits to prevent recurrence.

Additional control measures will include:

- Publication of the Trusts Fire Safety Policy RM04
- Publication of the Trusts Fire Safety Strategy Document
- Ensure all staff receive training relevant to their role, attending appropriate fire safety training courses provided to ensure that they have suitable and sufficient training for the role and responsibilities of individuals across the Trust. Including the introduction of a minimum 30-minute Fire Safety training package on commencing work for the trust as part of the general induction process.
- Support the production of the Trust Evacuation Plan and the programmed exercise to test this plan.
- Support ward management to ensure all wards and outpatient departments carry out specific evacuation training tabletop and walk–through exercises for all staff.
- Complete Fire Risk Assessments for all areas of the Ormskirk hospital site.
- Conduct external site visits to Trust premises to ensure statutory compliance with the Regulatory Reform (Fire Safety) Order 2005.
- Complete the Annual review of Trust wide Fire Safety Risk Assessments.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 JULY 2021**
Agenda Item	**TB122/21**	**FOI Exempt**	**NO**
Report Title	**PATIENT EXPERIENCE ANNUAL REPORT**		
Executive Lead	Bridget Lees, Executive Director of Nursing, Midwifery and Therapies		
Lead Officer	Lynne Barnes Deputy Director of Nursing & Midwifery Michelle Kitson, Patient Experience Matron		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This annual report provides an overview of Patient Experience during 2020/2021

Executive Summary

This report details an overview of Patient Experience in 2020/2021.

The Patient Experience Strategy 2020-2024 was approved by Trust Board in June 2020. Due to Covid-19 the strategy was relaunched in April 2021. The Patient Experience Strategy was developed drawing themes from multiple sources of patient feedback and incidents. Four key areas are identified which we will examine in the report.

- Aim 1: Listen to our patients, carers and families and respond to their feedback
- Aim 2: Provide a safe environment for our patients
- Aim 3: We will meet the physical and comfort needs of our patients
- Aim 4: We will provide a safe discharge for our patients

Going forward, the organisation plans to continue the momentum with the 'Discharge with Dignity' campaign, documentation of compliments, celebrating success and learning from Covid 19 to improve patient pathways and experience.

Recommendations

The Board is asked to note the report

Previously Considered By:

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

Strategic Objectives

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

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Lynne Barnes Deputy Director of Nursing, Midwifery and Therapies, Erica Isherwood Interim Corporate Nursing Team	Lynne Barnes Deputy Director of Nursing, Midwifery and Therapies

NHS
Southport and
Ormskirk Hospital
NHS Trust

ANNUAL PATIENT EXPERIENCE REPORT

2020 – 2021

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1. Introduction

This is the annual Patient Experience report for Southport and Ormskirk Hospitals NHS Trust 2020/2021.

The ambition is that all patients, carers and families from our local communities are engaged with, involved in their care and has a positive experience when they utilise our services. We want to ensure that their care is delivered by compassionate staff who are equipped with the skills to provide knowledgeable, compassionate, caring and safe care.

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

The four aims of the Patient Experience Strategy at the Trust encourage and enable us to listen to patients, carers and their families to understand what is required to improve and enhance care delivery.

The Organisation continually gain feedback via Friend and Family Test (FFT) results, Local and National Survey results, Patient Stories, National Audits, Compliments, Concerns and Complaints data, Maternity Voices Partnership and Healthwatch.

We continue to support both patients and carers through what can be one of the most vulnerable times in their lives, during an illness or hospital stay. This was further exacerbated during this reporting year as we have also supported service users during a global pandemic – never has patient experience been more significant or the care we provide had such an impact.

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

2. Covid 19 and Patient Experience

- We could not write a Patient Experience Report for this year without discussing Covid 19. This has been an exceptional year with unprecedented demands on the entire Trust. All staff worked tirelessly during the pandemic.

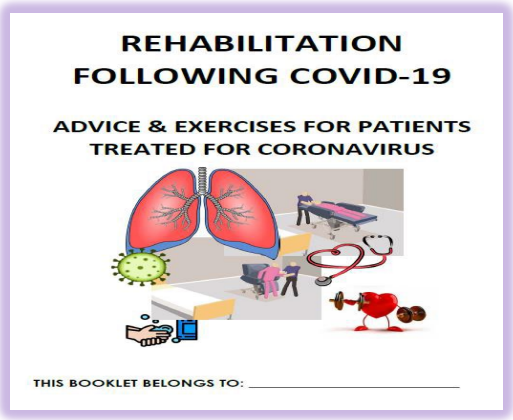
- The Critical Care Team won a Nursing Times Award for their video of how the Unit looked, explaining critical care and what patients might be experiencing. They also created photo badges so patients could feel reassured and see the care givers face despite it being under multiple layers of PPE.

- The Medical Day Unit was transferred to Ormskirk during Covid 19 without service interruption for some of our sickest and most vulnerable patients.

- A&E has been redesigned, which has resulted in a huge improvement for patients in the department, again through both waves of Covid 19.

- To reduce hospital stay the Trust collaborated to commission ten beds at Birkdale Park Nursing Home. This supported a rapid step down from hospital for those who were medically stable but remained significantly deconditioned, hence requiring enhanced therapy beyond the capabilities of the current community rehab bed bases. The therapy service from the acute Trust have been outreaching to ensure the patients have a seamless transfer of care and to provide daily therapy with the aim to return these people to their own homes. The results have been outstanding; not only has this concept reduced hospital stay, the majority of the patients who have flowed through this bed base have returned home. Without this facility, a large proportion of our patients would not have made the functional progression to return home and the likelihood being they would have transferred to long term care. Feedback included 'the family were so impressed by the quality of the care and physio support that we now wish she could have stayed longer.'

- Therapy Services provided rehabilitation to patients treated for Covid 19, some patients attended virtual clinics, some were referred to outpatients and all patients were referred for Community Pulmonary Rehabilitation.



- The Critical Care team volunteered and invited all patients to join Southport Critical Care ICU Steps Support Group.

- The A&E therapy team supported the oxygen home monitoring service (OHM) enabled patients with confirmed or suspected Covid 19 to be discharged home from A&E. The patients were given an oxygen saturation probe and were contacted daily by an occupational therapist or physiotherapist. They reviewed their oxygen saturation reading and overall health. 90% were able to avoid hospital admission due to this intervention. This enabled patients to be at home with their families from which they would have been separated from if admitted to the hospital. Verbal feedback from patients under the service was very positive.

- The Advanced Physiotherapy Practitioners (APPs) in the Trusts Integrated MSK Service mobilised to continue to ensure the effective and safe delivery of patient care during the Covid 19 pandemic. Significant channel shift in service delivery took place with monitored evaluation of outcome and effectiveness. A 'Virtual First' culture was adopted (Attend Anywhere). Acknowledging in some circumstances face to face maybe indicated. Following this 90% of patients are

very likely to somewhat likely to choose a video consultation again. Early data also shows trends of clinical effectiveness with assessment, treatment and management delivery in services.

- 2020/2021 has been a challenging year for the Patient Experience agenda. The Patient Experience and Community Engagement Group (PECEG) meetings were stood down during this period due to Covid 19 pressures. Despite resource challenges, the PECEG meetings have been reinstated with a view to continuing the work streams of the Patient Experience Strategy.

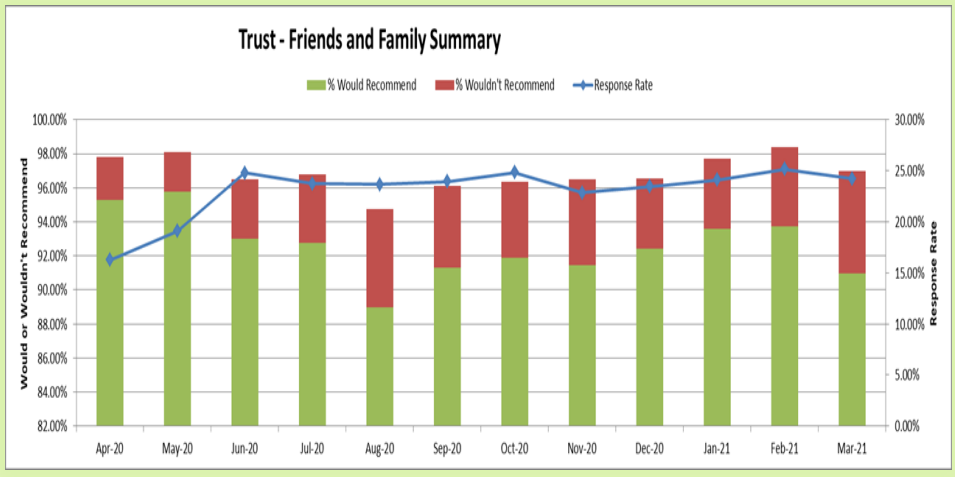
3. Aim 1: Listen to our patients, carers and families and respond to their feedback

- Via the Patient Experience and Community Engagement Group (PECEG) we have continued to work with external partners, such as Healthwatch and MVP, and gain feedback which helps the Trust gain a true understanding of the experience of our patients.

- MVP gives every woman on the maternity pathway to have a change to have her voice heard about the service she is receiving.

- In April the Trust responded to a Healthwatch letter regarding lost dentures. There are now corrective actions in place to resolve this issue with high visibility specialised pots available. The issue has been highlighted in the Trust via staff communications and the 'Mouth Care Matters' campaign will further help support this matter.

- The Friends and Family Test feedback is utilised by sharing it with staff, PECEG, Matrons and the Executive Board. Below is a graph for the question 'Would you recommend the hospital wards or accident and emergency unit to a friend or relative based on your treatment' 2020-2021.



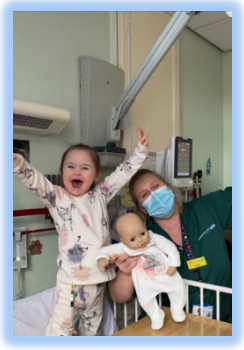
- National Patient Experience Surveys have all been delayed due to Covid 19 and we are currently up to date with all samples requested by Picker.

- The Complaints Annual Report has been published. The Trust has had a 16.8% decrease in complaints in the last year. The introduction of a

more front facing and accessible Patient Advice Liaison Service (PALS) has had a positive impact in de-escalating potential complaints and reaching early resolutions. We have also had an improvement in response times to formal complaints.

- The Trust collects patient stories to be shared monthly at Trust Board and at the Patient Experience and Community Engagement Group.

- Recently the Trust has heard experiences from Rosa and Poppy on the Children's Unit at Ormskirk. The Trust heard how the play room has re-opened with social distancing, a dedicated area for handover had been created to improve communication and a Children and Young Persons Forum is starting.



- Sarah shared her story at Board in April 2021 of early pregnancy loss with good ante-natal care and individuals recognised as outstanding. The Trust have increased resources since listening and learning to Sarah. Pathways have been reviewed with bereavement support and focus group.

- Alex described his experience of being a patient during Covid 19. He did not mind staff wearing masks or the clear screens between patient beds; in fact he thought they were a very good idea! He did miss his wife visiting but understood it was due to Covid 19 restrictions.

- The Trust has safely accommodated the loved ones of our patients that are at the end of life or are deemed vulnerable despite Covid 19. Women's and Children's services have also been able to facilitate parents or birthing partners to be present whilst adhering to infection control rules and national guidance.
- A plan is coming into effect soon to further introduce visitors to SIU, Rehabilitation Units and ICU. Patients will be encouraged to have one named visitor over 18 years of age. Safety of patients, families and staff throughout this process is of high importance so lateral flow tests, track and trace, temperature checks and PPE will all be utilised.

4. Aim 2: Provide a safe environment for our patients

- We have continued to strengthen our healthy Freedom to Speak Up (FTSU) culture with our established FTSU Guardian and Champions. The FTSU Annual Report highlights the ongoing positive impact raising concerns is having across the organisation. Over the last year 83 concerns have been raised through the FTSU process. Of course, the past year has been lived in the shadow of the Covid-19 pandemic. Nationally up to two thirds of FTSU 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. Saying that, the numbers show that concerns have still been raised and highlights the accuracy of the CQC statement following their visit and subsequent report of November 2019.

- During the Covid 19 pandemic the chaplaincy and spiritual care service has been able to maintain a full service (on call and regular follow up visits). We continued to receive a significant number of referrals from faith communities, patients themselves, wards and families. Over the year at times, staffing has been a challenge, with some staff having to shield and some on call chaplains withdrawing.

- During the autumn period, chaplaincy and spiritual care annually puts on three events, specifically a memorial event, a wave of light service as part of the annual baby loss week, and a baby and child loss service, usually in the baby garden at Ormskirk.

- The wave of light service was recorded the night before and broadcast on the closed bereavement support group Facebook and not made public, due to the sensitivity of the use of babies' names.

- The memorial service and the baby and child loss service was recorded in advance and premiered on the hospital YouTube channel (and other platforms) and was met with an overwhelmingly positive response.

- Given that the memorial service has now had over a thousand views, and people are still being encouraged to watch this as part of their bereavement

journey, and the baby and child loss service has been viewed by at least double the number who would usually attend, this does raise some questions about how we might manage these events going forward.

- Although the baby garden at ODGH could not be used by members of the public, the Christmas tree outside the hospital was available for anyone to leave the name of a loved one on (baby or any age). Likewise the tree in the garden of reflection at SDGH was used in a similar way. 36 knitted angels were sent out to families to use on their own Christmas tree in memory of a baby within their family.

- The memorial service was linked to the planting of bulbs and ribbons outside of the hospitals and in the spring, and we are thinking we may arrange some event around the bulbs coming to fruition.

- To highlight the work of chaplaincy and spiritual care, spiritual care champions are currently being appointed.

- The Trust produced a press release about chaplaincy during a pandemic, which was used both locally and nationally and the hospital Chaplains have had opportunity to share insights as part of the Daybreak programme on Radio Merseyside.

- The Trusts Chaplin also did a follow-up interview on Radio Merseyside at the beginning of January in relation to chaplaincy and spiritual care at the hospital, and has been asked on a couple of occasions to offer some words of reflection and support for the bereaved by Rock FM.

- Safe staffing is reviewed daily through the staffing huddles and local and international recruitment plan in place for registered and healthcare assistance roles.

- The ‘Shaping Care Together’ programme continues consulting with service users and engaging clinical teams during re-design of local health care services, including fragile services.

- Quality Matrons are working with wards and departments to deliver quality improvements in line with clinical audit findings and to sharing good practice across the organisation.

- Equality Impact Assessments (EIA) are completed at the beginning of any service changes or re-designs.

- Wards at Southport are undergoing minor refurbishments and deep cleans, this will provide an improved environment for patients and staff.

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

- There has been ongoing recruitment of volunteers across the organisation. Volunteer dining companions will be back in the Trust assisting with meal times when visiting is started on the adult wards.

- The Trust has provided Dementia strategy has centres to all activity areas and activity co-ordinator training is to commence in June 2021 with 30 co-ordinators identified. The Trust has recently been visited by the Dementia Bus which can give staff a virtual experience of what it is like to live with dementia, this will enable them to have more understanding and care for our patients.

- Perfect Ward (facilitated via mobile application) records elements of nutritional and oral care and patients comfort needs delivered at ward level. This is data is included in ward dashboards to monitor quality outcomes.

- Trust performance around Malnutrition Universal Screening Tool (MUST) required an increased focus to improve. The Quality Matron team provide support to wards in order to deliver improvements which will ensure that 95% of patients admitted have a nutritional assessment during the first 24 hours of admission. MUST is monitored via the ward dashboards and scores have improved.

- We have purchased 18 new patient transfer scales to ensure weighing of patients on admission which aligns to them receiving appropriate nutritional care. This helps ensure continued assessment of weight is carried out during inpatient stay.

- Patients have choice and access to safe nutritious food and hydration, with menus devised from government guidelines and approved by Trust dieticians. They follow the 10 Key characteristics of good nutrition and hydration and the nutrition group meet on a regular basis. Calorific values are to be added to menus.

- Vegan diet is now catered for, with menus for patients and staff.

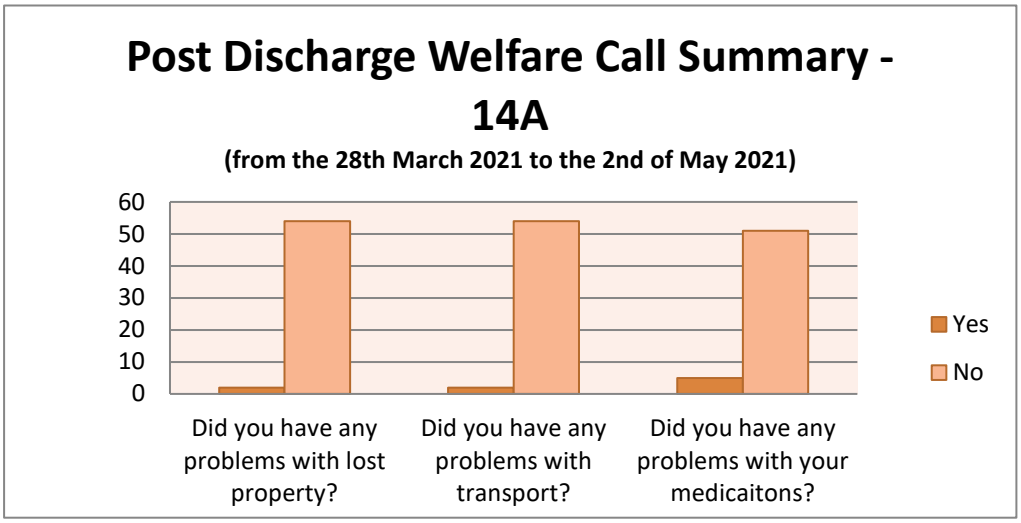
- A&E now have a snack trolley which provides regular refreshment rounds, improving nutrition needs and patient experience in the department.

- There has been a considerable amount of work done to monitor the temperatures of food arriving at ward level. After some investigation it was found that it can sometimes be down to the time between delivery and serving the food rather than the temperature it actually arrives at. This has been improved by meal trolleys arriving at wards at a designated time; this enables staff to know when it is coming and to be free to serve the food whilst it is still hot.

- Patients are requesting butter not margarine. This has led to the 'Bring back Butter' campaign on Spinal Injuries Unit. This has now been successfully implemented.

- The Neonatal Unit at Ormskirk have been successful in a very competitive application process to be part of the UNICEF UK Baby Friendly Initiative. Over half the neonatal units in the country applied and only 18 were chosen for this National Neonatal Project. It aims to transform healthcare for babies, their mothers and families. It helps support families with feeding and developing close loving relationships ensuring the best start in life.

6.



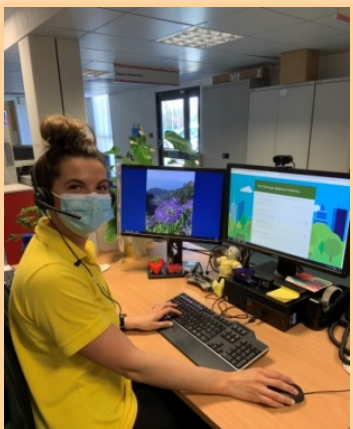
Aim 4: We will provide a safe discharge for our patients

- A new discharge follow up pilot programme with volunteers has started, with volunteers completing welfare checks via telephone to patients from nominated ward areas within the pilot. Thus far, over 800 telephone calls have been made to patients discharged home from hospital within 24-72hrs. Early feedback is reflecting very positively against the services. Below is an example of one of the wards.

- A Quality Improvement programme is in place and thematic reviews are ongoing. The aim is to ensure patients feel supported and involved in discharge from hospital, information about medications and knowing who to contact with any concerns about treatment or clinical condition.

- There is now increased presence of pharmacists on our ward areas and in AED to provide support to patients and assess their medicines. Pharmacy technician's support is under review post pilot.

- A new and improved discharge booklet and checklist have been developed and implemented help keep patients informed and prompt any questions they or their families may have. These will also assure patients are safely discharged and discharged with dignity.



7. Going Forward

- We aim to continue to heighten the profile of our patient journeys within Southport and Ormskirk Hospital NHS Trust and promote a positive patient experience. This is a shared responsibility of all staff within the organisation.

- Patient Experience is constantly evolving as we aim to provide the best standard of care for our patients and families.

- The very first Patient Experience Conference will take place in June 2021. All the Clinical Business Units, the volunteer service and Freedom to Speak Up Guardian will all be able to showcase the fantastic work they have done over the last year, a real celebration for the Patient Experience agenda.

- 'Thank you Thursday' is an initiative that was raised at the Patient Experience Community Engagement Group in May and the Trust will soon be adopting it in due course. This will be a way patients can nominate staff and be able to say thank you for the care they received.

- The Patient Experience and Community Engagement Group will be encouraging staff to document compliments on the Datix system. All areas in our Trust regularly receive thank you cards, verbal thanks, letters, emails and complements on social media and it is just about getting those documented and sharing our success stories.

- Moving forward mobile Apps will continue to support services. A tool kit approach will be championed that is a blended delivery; video consultation, phone consultation and face to face. From June 2021 the current face to face offer will be tripled following staff listening events and true co-design with patients with lived experience in some clinical teams.

- Quality Improvement going forward is at the heart of everything we do. The Trust is committed to ensuring families are involved with end of life care and DNACPR. Every effort will be made to ensure patients do not die alone.

- Local and system learning will continue for discharges.

- Nutrition and hydration will have continuous assessments to give full assurance that our patient's needs are met.

- To conclude, the last year has been unprecedented due to the global pandemic but patient experience, and safety, has been at the heart of the care we deliver.

We will continue to listen, learn and improve throughout 2021/2022, and beyond.