

AGENDA

STRATEGY AND OPERATIONS (S&O) COMMITTEE

To be held at 0930 on Wednesday 06 October 2021

V = Verbal D = Document P = Presentation

Ref N ^o :	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				0930
SO001/21 (V)	Chair's welcome and note of apologies <i>Purpose: To record apologies for absence and confirm the meeting is quorate.</i>	No	Chair	
SO002/21 (V)	Declaration of interests <i>Purpose: To record any Declarations of Interest relating to items on the agenda.</i>	No	Chair	5 mins
STRATEGIC CONTEXT				0935
SO003/21 (V)	Chair's Introduction to the Agreement for Long Term Collaboration (ALTC) <i>Purpose: To welcome all members to the new Committee and to note the Terms of Reference</i>	No	Chair	10 mins
SO004/21 (V)	Chief Executive's Introduction <i>Purpose: To introduce the Agreement for Long Term Collaboration (ALTC)</i>	No	CEO	10 mins
INTEGRATED PERFORMANCE REPORT				1010
SO005/21 (D)	Integrated Performance Report (IPR) a) Integrated Performance Report Summary b) Activity c) Quality and Safety d) Workforce e) Operations f) Finance <i>Purpose: To note the IPR for assurance</i>	No	Lead Executive	25 mins
QUALITY & SAFETY				1035
SO006/21 (D)	Quality and Safety Reports a) Committee AAA Highlight Report	No		25 mins

- | | |
|---|----------------|
| b) Summary Report of changes to IPC Assurance Framework | Cttee
Chair |
| c) Safe Nursing and Midwifery Staffing Report | MD |
| d) To receive Annual Reports for Safeguarding and Medical Appraisal and Revalidation (approved by Quality and Safety Committee) | DoN |

Purpose: To receive the Quality and Safety reports

WORFORCE 1100

SO007/21	Workforce Reports	No		20
(D)	a) Committee AAA Highlight Report		Cttee	Mins
	b) <i>Guardian of Safe Working Report</i>		Chair	
	c) <i>Freedom to Speak Up Report</i>		DoHR	
			MD	
			DoN	

Purpose: To receive the reports for information and assurance.

FINANCE, OPERATIONS AND INVESTMENT 1120

SO008/21	Finance, Performance and Investment Reports	No		15
(D)	a) Committee AAA Highlight Report		Cttee	mins
	b) 2021/22 Winter Plan		Chair	
	c) Month 5 Finance Report		COO	
			DoF	

Purpose: To receive the FPI reports for information and assurance

CONCLUDING BUSINESS 1150

SO009/21	Questions from Members of the Public		Chair	10
(V)	<i>Purpose: To respond to questions from members of the public received in advance of the meeting.</i>			mins
SO010/21	Message from the Committee		Chair	
(V)	<i>Purpose: To approve the key messages from the Committee for cascading throughout the organisation</i>			
SO011/21	Any Other Business		Chair	
(V)	<i>Purpose: To receive any urgent business not included on the agenda</i>			

Date and time of next meeting:	1200
0930 Wednesday 03 November 2021	close

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

The Strategy and Operation Committee resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Chair

Chair: Richard Fraser

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	6 October 2021
Agenda Item	SO005/21	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	<input type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
To provide an update on the Trust's performance against key national and local priorities.			
Executive Summary			
<p>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.</p> <p>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.</p>			
Recommendation			
The Committee is asked to receive the Integrated Performance Report detailing Trust performance in August.			
Previously Considered By:			
<input checked="" type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee		<input checked="" type="checkbox"/> Quality & Safety Committee <input checked="" type="checkbox"/> Workforce Committee <input type="checkbox"/> Audit Committee	
Strategic Objectives			
<input checked="" type="checkbox"/> SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services			
<input checked="" type="checkbox"/> SO2 Deliver services that meet NHS constitutional and regulatory standards			
<input checked="" type="checkbox"/> SO3 Efficiently and productively provide care within agreed financial limits			
<input checked="" type="checkbox"/> SO4 Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated			
<input checked="" type="checkbox"/> SO5 Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values			
<input checked="" type="checkbox"/> 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	

Strategy and Operations Committee - Integrated Performance Report

Head of Information Summary

The Trust's Integrated Performance Report covers four 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*

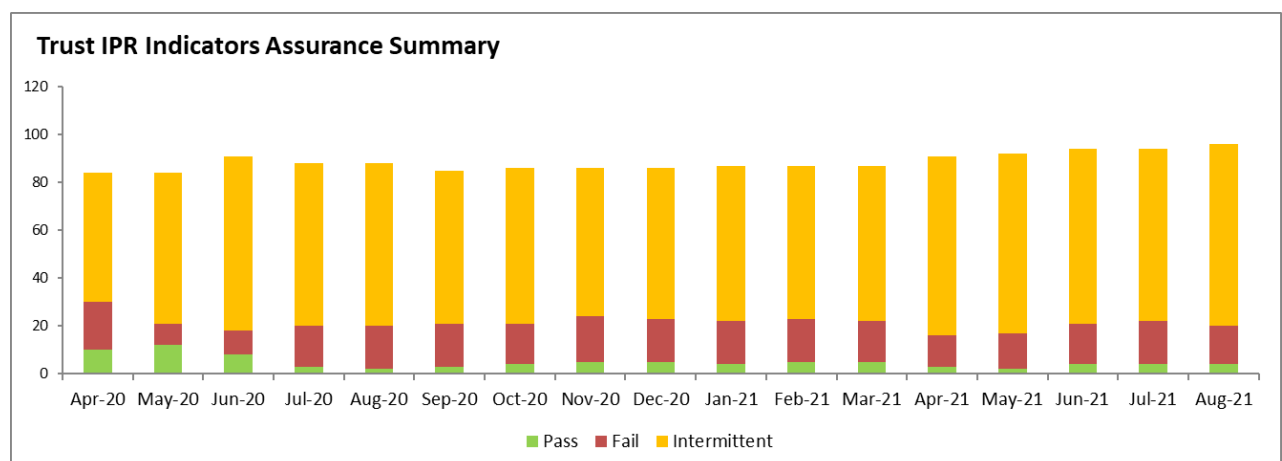
Finance - **S03** – *Efficiently and productively provide care within agreed financial limits.*

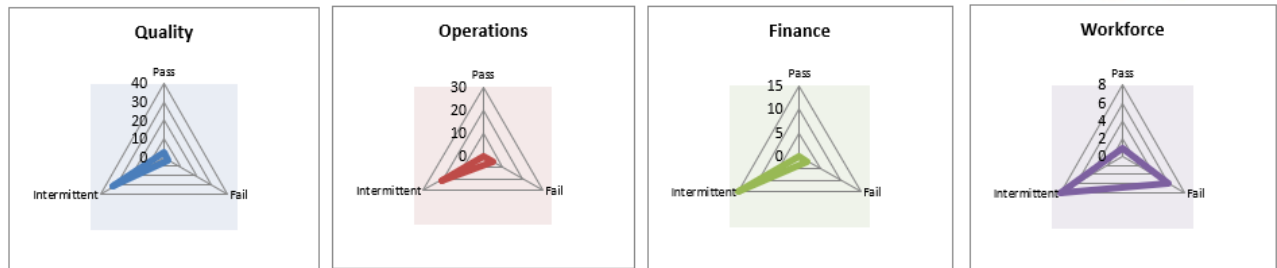
Workforce - **S04** – *Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated* and **S05** – *Enable all staff to be patient-centred leaders building an open and honest culture and the delivery of the Trust values.*

The majority of indicators in this month's IPR are still classed as intermittent. Only Care Hours Per Patient Day, HSMR, Friends and Family Test - Patients - % Response Rate and Mandatory Training are classed as fully assured.

The following AAA will highlight any specific areas to the Committee 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	Jun-21	Jul-21	Aug-21
Pass	10	12	8	3	2	3	4	5	5	4	5	5	3	2	4	4	4
Fail	20	9	10	17	18	18	17	19	18	18	18	17	13	15	17	18	16
Intermittent	54	63	73	68	68	64	65	62	63	65	64	65	75	75	73	72	76





ALERT

Quality: Metrics to be alerted to this month include the % of deaths screened, at 6.8% this is the lowest figure ever reported. A Hospital Onset Hospital Acquired MRSA case has been reported for the first time since January, although the investigation did not identify any lapses in care.

Safe Staffing failed to achieve the 90% target for the last two months. This has been impacted by high sickness rates amongst both Registered and Un-Registered Nurses and annual leave over the summer period. Three breaches of 1:1 care have been reported in Maternity in the last two months. These are relating to the staffing pressures of the Unit and high levels of activity.

Finance & Operations: Performance against constitutional standards continues to fail to meet national targets as the Trust continues its recovery – this includes ED performance, Diagnostic performance, RTT and Cancer. ED performance has been impacted by high demand and high bed occupancy. Diagnostic performance has declined across all modalities and at 34.8% is the highest proportion of patients waiting longer than six weeks since June 2020. Cancer 14-day performance continues to be impacted by Endoscopy and capacity within Gynaecology. The RTT waiting list continued to grow and stands at 12,595 in August. The elective restoration programme was impacted over the summer period by annual leave, sickness and the pandemic and is below trajectory.

CIP targets continue to be a challenge across all CBU's and has been raised as an Alert in each CBU's monthly PIDA meeting. In addition, premium rate staffing costs have adversely affected the financial run rate.

Workforce: Indicators which the Committee should be alerted to this month include the Sickness Rate (not related to Covid-19), which has remained at 6% for two consecutive months. Sickness rates for Registered and Un-Registered Nursing have both increased in August. Also this month Nursing Staff Turnover has increased to 1.4%.

Maternity staffing continues to be a concern, root cause analysis has been completed and HR are supporting the team on tackling issues with sickness in the department.

ADVISE

Quality: To advise the Committee, the Trust SHMI is improved this month at 100.9 and is classed as 'as expected'. It is at the lowest level since before the pandemic.

There has been an increase in the number of Hospital Acquired Category 3 Pressure Ulcers with five reported in August. All are being investigated through the Harm Free Care process. Both the Caesarean and Induction rates are much improved this month and are in-line with the targets. Whilst still remaining below target, the Friends & Family Test – Patient - % that would recommend, has increased in August, due to significant improvements within Women & Children's.

Finance & Operations: There has been an increase in demand for CT and Non Obstetric ultrasound (NOUS) scans, the Trust will be utilising Renacres for NOUS as part of the H2 plans for Independent Sector (IS) provision. The Trust is also supporting a bid from WLCCG

for funding to provide community diagnostics hub in the community which will provide a range of diagnostic services but this will not be implemented for a number of months if successful.

Stroke performance remains below target at 65.6% although the Committee should be assured that no harms have been caused. The work of the Stroke Improvement Group continues.

Theatre Utilisation at ODGH remains on an upward trajectory despite decreased activity.

Workforce: This month's advisory notices include the position for Personal Development Reviews, which at 78.6% is the highest level for more than two years. Whilst the Nursing Vacancy rate remains static, it is well below the rates seen in 2019/20 and 2021/21.

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 74 continues an excellent trend with no diagnosis level SMR's exceeding 100 this month. In the Patient Experience section both Duty of Candour indicators are 100%, and have been for an extended number of months. WHO Checklist also maintains 100% compliance

Incident reporting remains high across all CBU's, whilst rates of moderate harm incidents remain low, demonstrating a positive incident reporting culture.

Breastfeeding initiation has increased significantly in August and has been in excess of the target for the last 8 months.

Finance & Operations: Despite increased demand on adult ED services ambulance handover times continue to show recent positive variation which should provide assurance to the Committee. In addition, there remains zero patients treated in the corridor in ED despite increasing demand.

Compliance with performance for the inclusion of D and P codes in weekly waiting list submissions has seen the Trust meet national targets well in advance of the target in December, this is one of the ERF gateways for national funding.

Data Quality of national waiting list submission has now met the required 95% confidence target well ahead of the December target. This is also an ERF gateway.

The Trust maintained 100% compliance against the Cancer 31-day treatment metric for the third consecutive month.

Workforce: Metrics which can provide assurance to the Committee include the Mandatory Training rate, which has increased further in August and at 88.8% remains above the 85% target.

The Medical Vacancy rate continues an improving trajectory, at 6.9%, the lowest for more than 2 years.

Activity Summary – August 2021

Indicator Name	August 2019	August 2020	July 2021	August 2021	Trend
Overall Trust A&E attendances	10,396	8,860	10,324	9,403	▲
SDGH A&E Attendances	5,169	4,633	5,397	5,305	▲
ODGH A&E Attendances	1,955	1,333	2,801	1,970	▲
SDGH Full Admissions Actual	1,242	1,233	1,289	1,264	▲
Stranded Patients AVG	166	144	153	159	▲
Super Stranded Patients AVG	65	44	42	46	▲
MOFD Avg Patients Per Day	65	36	44	43	▲
GP Referrals (<i>Exc. 2WW</i>)	2,300	1,406	1,812	1,613	▲
2 Week Wait Referrals	744	732	961	866	▲
Elective Admissions	162	120	196	144	▲
Elective Patients Avg. Per Day	5	4	6	5	▲

Activity Summary – August 2021

Indicator Name	August 2019	August 2020	July 2021	August 2021	Trend
Elective Cancellations	22	25	42	58	▲
Day case Admissions	1,941	1,114	1,518	1,202	▲
Day Case Patients Avg. Per Day	63	36	49	39	▲
Day Case Cancellations	40	11	68	82	▲
Total Cancellations (EL & Day Case)	62	36	110	140	▲
Total Cancellations (On or after day of admission, non clinical reasons)	7	0	6	3	▲
Outpatients Seen	21,202	17,514	21,724	18,768	▲
Outpatients Avg. Per Day	684	565	701	605	▲
Outpatients Cancellations	4,538	4,083	4,188	3,959	▼
Theatre Cases	620	360	624	478	▲
General & Acute Beds Avg. Per Day	411	418	400	403	▼
Escalation Beds Avg. Per Day	2	0	0	0	
In Hospital Deaths	52	60	75	77	▲

Integrated Performance Report Board Report

August 2021

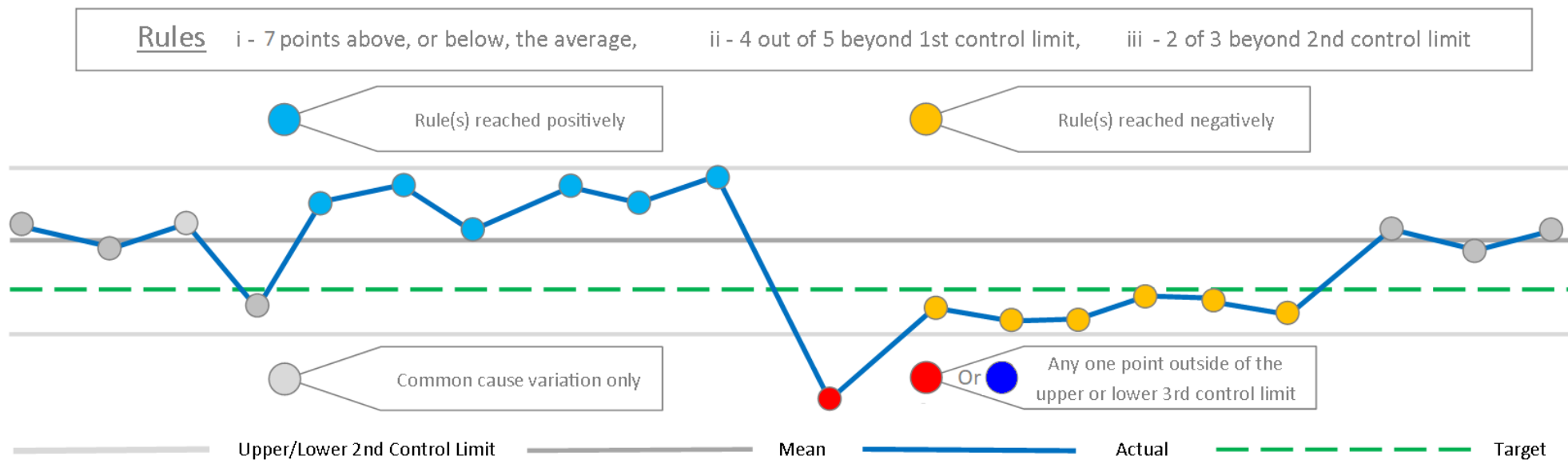
Guide to Statistical Process Control

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

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

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

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



Executive Summary

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

Assurance	
Measures the likelihood of targets being met for this indicator.	
	Indicates that this indicator is inconsistently passing and falling short of the target.
	Indicates that this indicator is consistently passing the target.
	Indicates that this indicator is consistently falling short of the target.

Variation (Past 3 Months)	
Whether SPC rules have been triggered positively or negatively overall for the past 3 months.	
	Indicates that there is no significant variation recently for this indicator.
	Indicates that there is positive variation recently for this indicator.
	Indicates that there is negative variation recently for this indicator.

Quality

Harm Free

Analyst Narrative:

One indicator within this section continues to be assured: Care Hours per Patient Day (CHPPD). The WHO Checklist also continues to show special cause improvement, maintaining 100% performance in August. Whilst not statistically significant, there has been an increase in Hospital Acquired Category 3 and 4 Pressure Ulcers, with 5 reported in August. Similarly, although the % of FNOF patient beings operated on within 36hrs remains statistically as expected, 13 patients breached this measure in August. Safe Staffing has also failed to achieve the 90% target for the second consecutive month.

Operational Narrative:

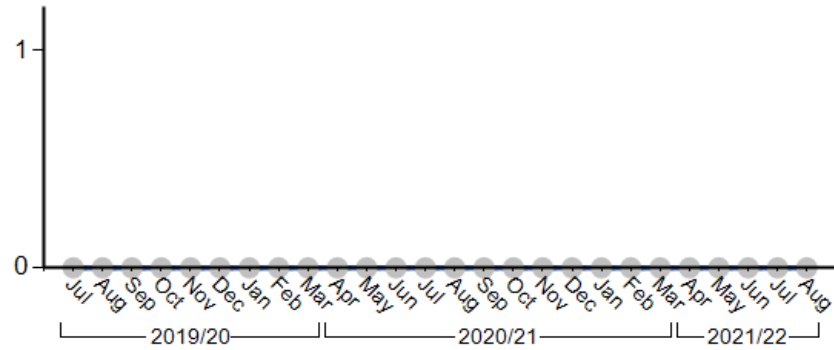
Category 3 & 4 Pressure Ulcers – One of the reported category 3 pressure ulcers has been identified as unavoidable due to the patient's long-term condition. The remaining 4 are currently undergoing investigation and will be presented to the Harm Free Care Panel with any identified learning disseminated to the relevant areas.

Eight of the patients who failed to have their FNOF operated on within 36hrs were delayed due to their medical condition. The remaining five were impacted by theatre capacity.

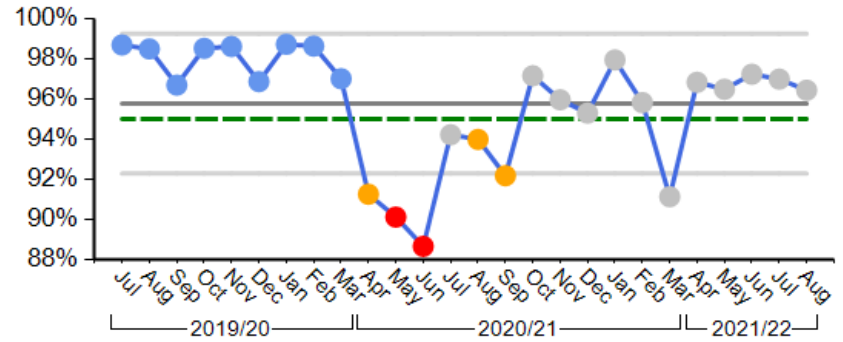
Monitoring of staffing occurs twice daily with a view to ensuring fill rates are acceptable and patient safety. Issues remain reflective of the ongoing pandemic where staffing shortages due to isolation and sickness remain. Acuity of patients continues to impact on staffing requirements as we utilise with use of our own NHSP nurse bank to support shortfalls. Despite this actual staffing versus planned staffing does fall short of the national 90% standard, we continue to report staffing levels through relevant channels on a daily basis. International nurse recruitment continues with high levels of success and local recruitment events are planned to bolster substantial staff numbers.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Never Events	0	0	0	Aug 21		0	0	Jul 21	0	0	
VTE Prophylaxis Assessments	95%	96.4%	131	Aug 21		95%	97%	Jul 21	95%	96.8%	
Fractured Neck of Femur - Operated on within 36Hours	85%	58.1%	13	Aug 21		85%	73.1%	Jul 21	85%	71.8%	
WHO Checklist	100%	100%	0	Aug 21		100%	100%	Jul 21	100%	100%	
Safe Staffing	90%	87.2%	N/A	Aug 21		90%	87%	Jul 21	90%	89.2%	
Care Hours Per Patient Day (CHPPD)	7	9	N/A	Aug 21		7	8.8	Jul 21	7	9	
StEIS	0	3	3	Aug 21		0	0	Jul 21	0	12	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.5	6	Aug 21		0.5	0.2	Jul 21	0.45	19	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.4	5	Aug 21		0.1	0	Jul 21	0.1	8	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	1.3%	12	Aug 21		2.1%	0.3%	Jul 21	2.1%	0.8%	
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.1	1	Aug 21		0.1	0.1	Jul 21	0.1	0.1	

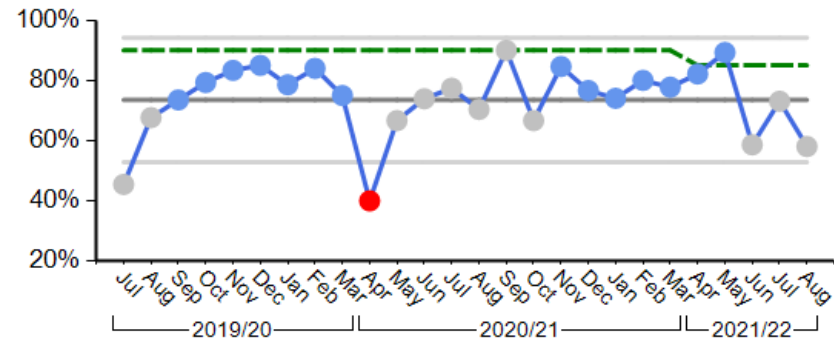
Never Events



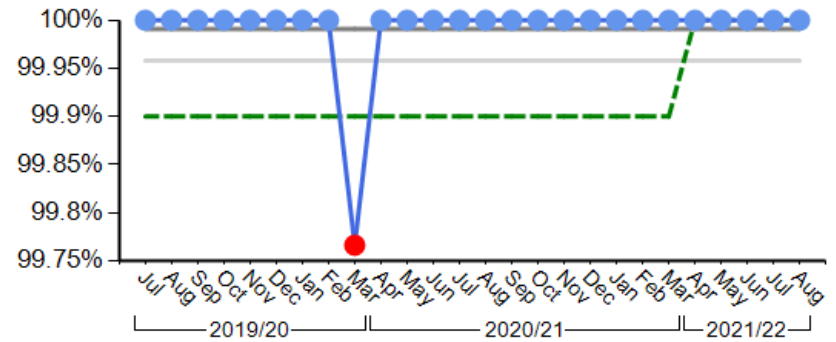
VTE Prophylaxis Assessments



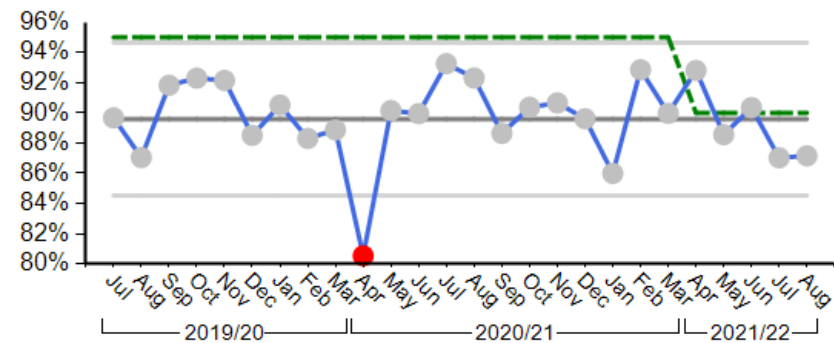
Fractured Neck of Femur - Operated on within 36Hours



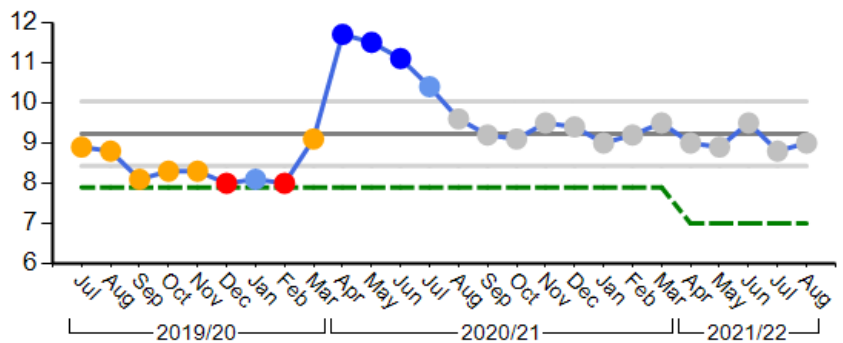
WHO Checklist



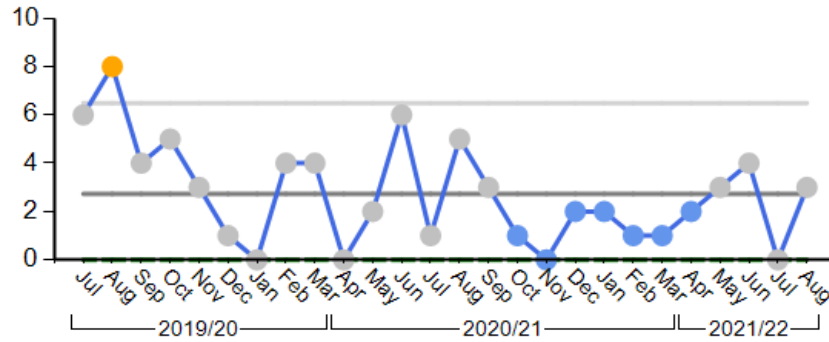
Safe Staffing



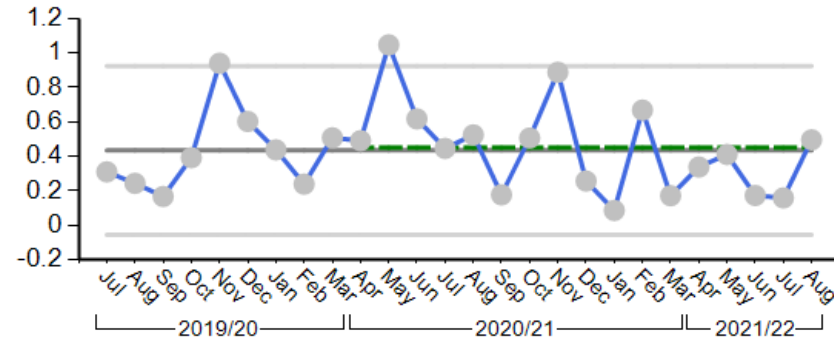
Care Hours Per Patient Day (CHPPD)



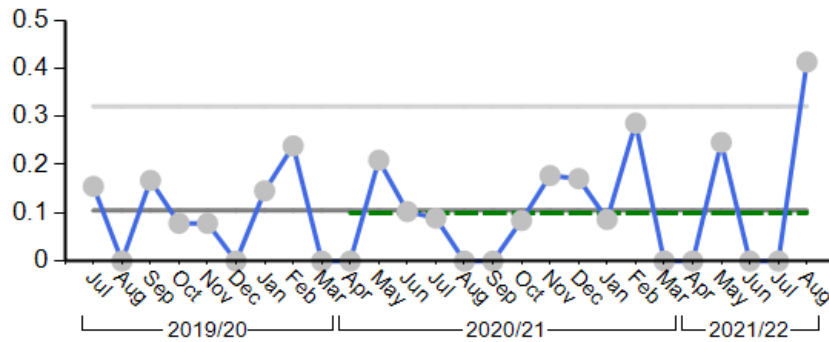
StEIS



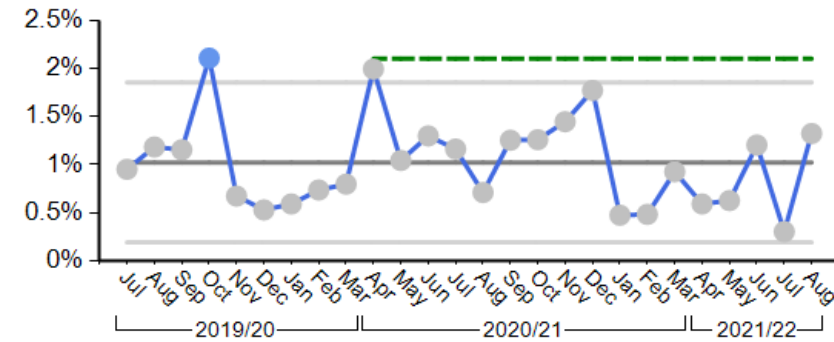
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



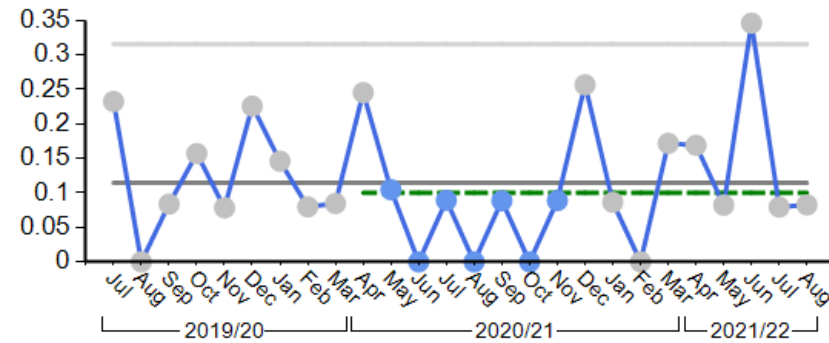
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



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 or failing their assurance measure, with intermittent performance. A case of MRSA in August has resulted in this metric showing special cause concern. E-Coli and MSSA are both showing recent special cause concern due to increases in previous months, performance for both these indicators is improved in August and statistically as expected. C.diff infection rates have fallen below the mean in August.









Operational Narrative:

MRSA – one Hospital Onset Hospital Acquired (HOHA) case was reported relating to a Medical Ward. This has been investigated and there were no apparent lapses in care.

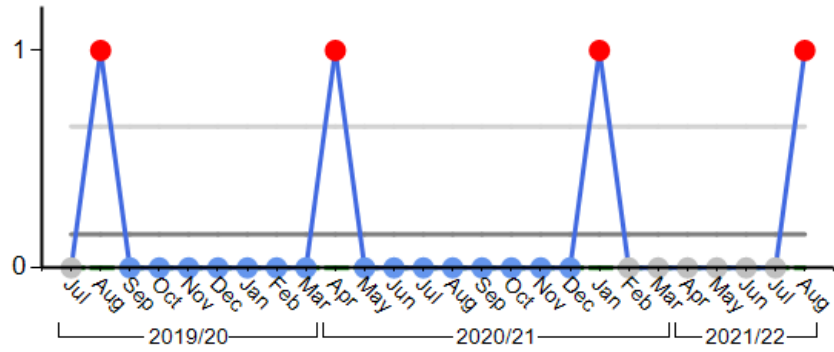
C. diff – three Hospital Onset Hospital Acquired cases were reported in August. Two related to Medical Wards and the investigations identified delays in isolation, specimen acquisition and antibiotic issues. The third case related to a Planned Care ward and is currently being investigated.

E coli - three Hospital Onset Hospital Acquired cases were reported in August. Two were on Medical Wards and one was Planned Care. All three have been investigated and there were no apparent lapses in care.

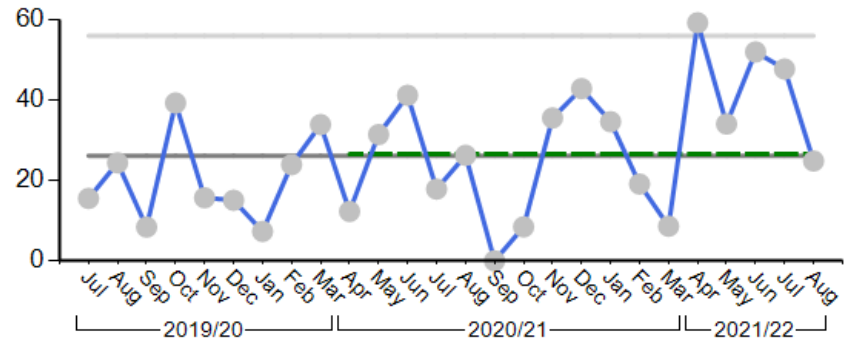
MSSA – two Hospital Onset Hospital Acquired were reported, both relating to Medical Wards. One has been investigated and identified no lapses in care. The second is currently under investigation.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
MRSA	0	1	1	Aug 21		0	0	Jul 21	0	1	
Clostridium Difficile - per 100,000 bed days	26.5	24.8	3	Aug 21		26.5	47.7	Jul 21	26.5	43.4	
E. Coli - per 100,000 bed days	20.6	24.8	3	Aug 21		20.6	39.7	Jul 21	20.6	33.2	
MSSA - per 100,000 bed days	8.8	16.5	2	Aug 21		8.8	39.7	Jul 21	8.8	16.6	

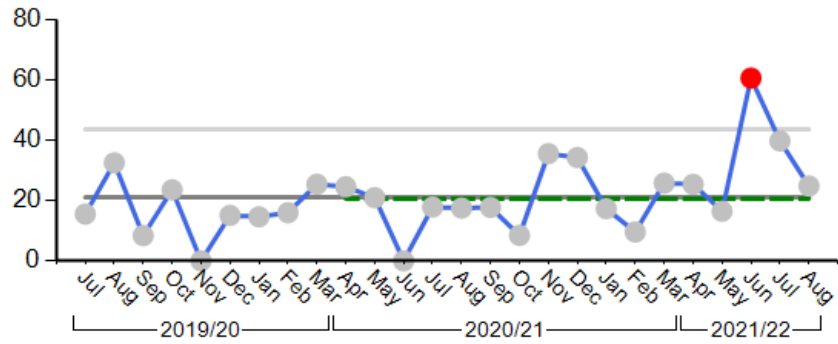
MRSA



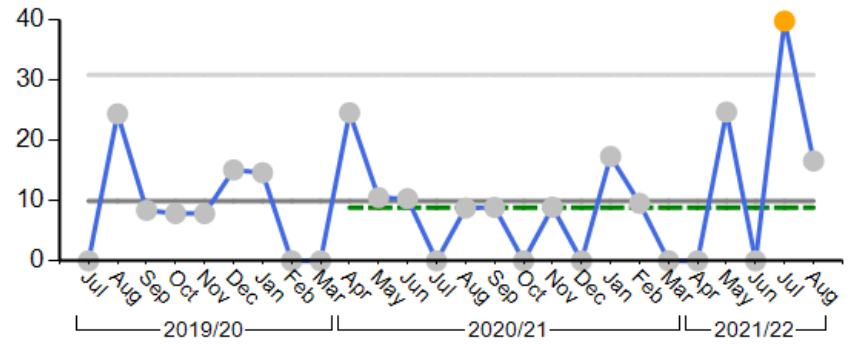
Clostridium Difficile - per 100,000 bed days



E. Coli - per 100,000 bed days



MSSA - per 100,000 bed days



Maternity

Analyst Narrative:

The number of occasions 1:1 care is not provided is showing special cause concern. Following 18 months of no breaches, June – August all reported breaches. Caesarean rates are showing special cause concern due to the spike in June, however performance in August is at the lowest level for 12 months and almost in line with the target. Similarly, the induction rate has also declined to close to the target, and the lowest recorded since February 2021. Breastfeeding initiation shows special cause improvement, with a significant increase in August which is 5.5% above the Trust's stretch target.

Operational Narrative:























Stillbirth Rate - There was one stillbirth in August 2021. A 72-hour review was completed and presented at SIRG with no immediate actions identified. This will be subject to a PMRT review.

Number of Occasions 1:1 Care Not Provided – 1:1 care has not been provided 3 times for the period July (2) and August (1) and is the first time in over 18 months. This reflects the staffing pressures which have been experienced in the last few months.

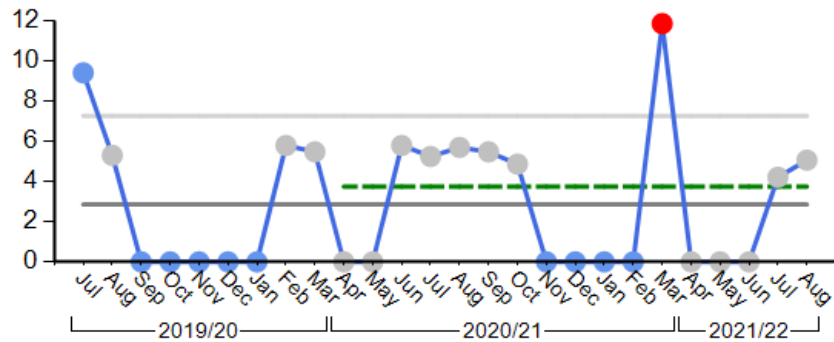
Caesarean Rates and Induction of Labour - This month both Inductions and Caesarean section rates are within plan. An audit has been completed for induction with recommendations based on findings. The audit will be presented at this month's Trust Quality & Safety Committee and Trust Board.

Percentage of Women booked by 12 weeks 6 days – All breaches are subject to a review.

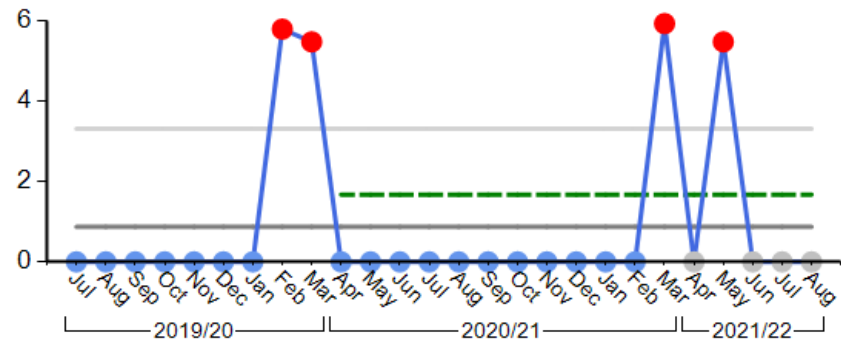
3rd and 4th Degree Tears – 3rd and 4th degree tears from unassisted births increased in month with four reported cases. All cases have been reviewed and care was appropriate. There are no themes with midwife conducting births.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Stillbirth Rate (per 1,000 births)	3.74	5.1	1	Aug 21		3.7	4.2	Jul 21	3.74	2	
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Aug 21		1.7	0	Jul 21	1.67	1	
Number of Maternal Deaths	0	0	0	Aug 21		0	0	Jul 21	0	0	
Caesarean Rates	28.5%	28.8%	57	Aug 21		28.5%	34.1%	Jul 21	28.5%	34.8%	
Induction Rate	38%	38.9%	77	Aug 21		38%	42.5%	Jul 21	38%	44.2%	
Breastfeeding Initiation	62%	67.5%	64	Aug 21		62%	64.7%	Jul 21	62%	64.4%	
Percentage of Women Booked by 12 weeks 6 days	90%	91.2%	16	Aug 21		90%	90%	Jul 21	90%	90.7%	
Number of Occasions 1:1 Care Not Provided	0	1	1	Aug 21		0	2	Jul 21	0	4	
Maternity Complaints as % of Deliveries	0.7%	1%	2	Aug 21		0.7%	0.4%	Jul 21	0.7%	0.6%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	3.7%	4	Aug 21		1.5%	2.4%	Jul 21	1.5%	2.8%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	4.2%	1	Aug 21		11%	0%	Jul 21	11%	4.3%	

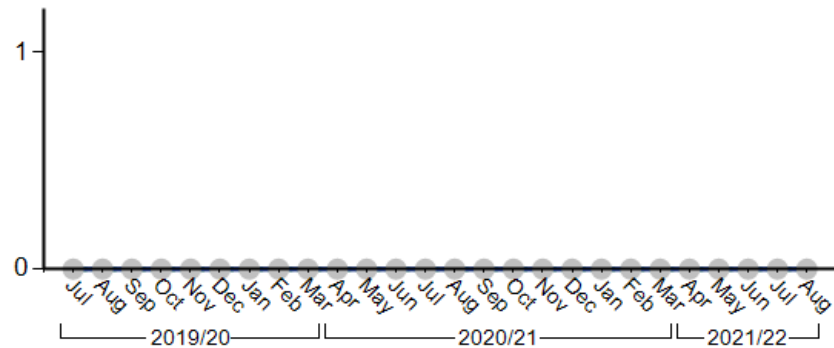
Stillbirth Rate (per 1,000 births)



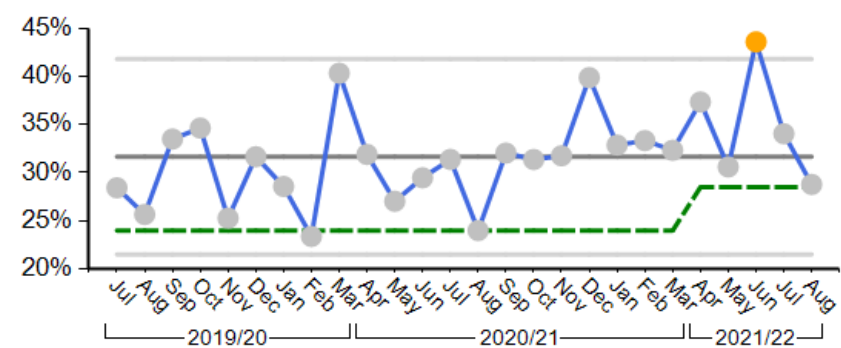
Neonatal Mortality Rate (per 1,000 births)



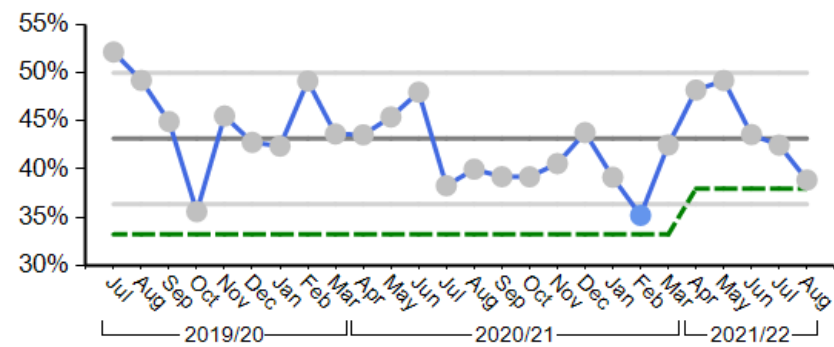
Number of Maternal Deaths



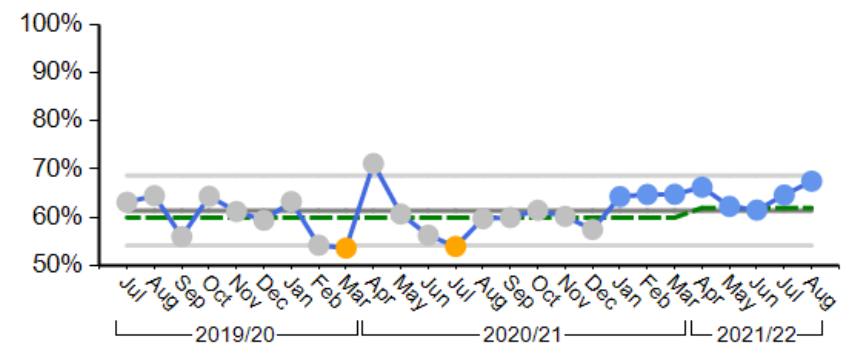
Caesarean Rates



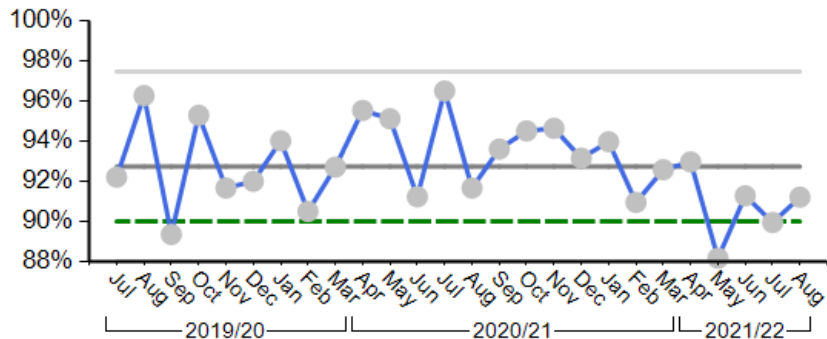
Induction Rate



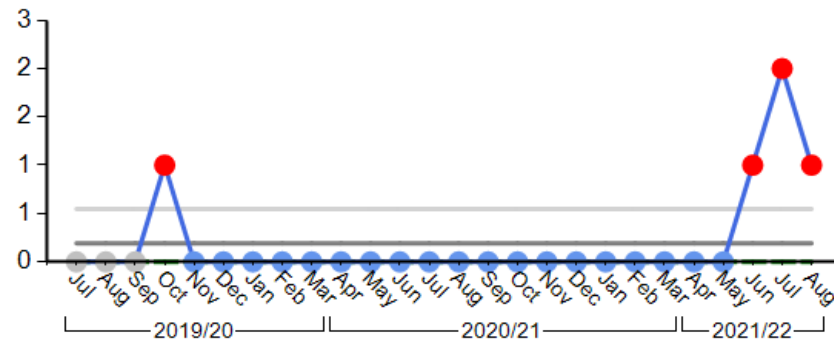
Breastfeeding Initiation



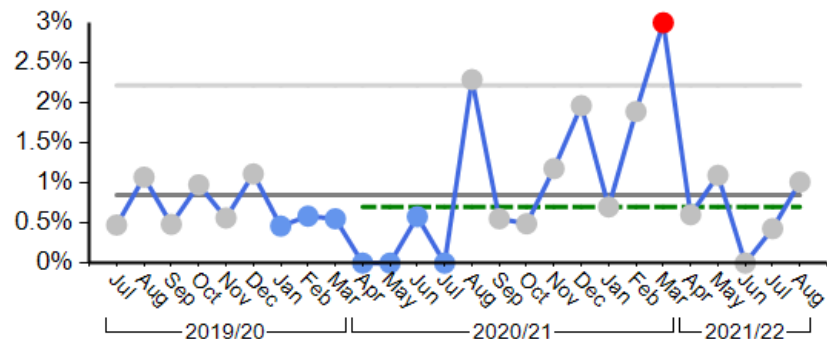
Percentage of Women Booked by 12 weeks 6 days



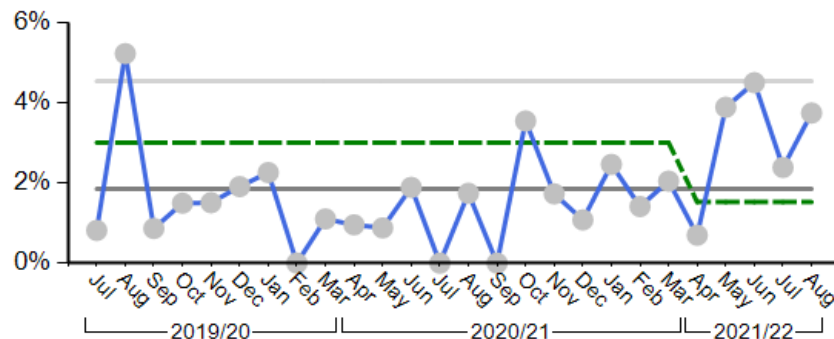
Number of Occasions 1:1 Care Not Provided



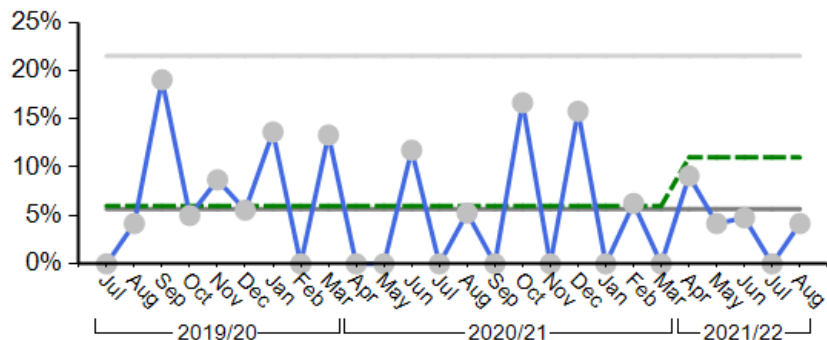
Maternity Complaints as % of Deliveries



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











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



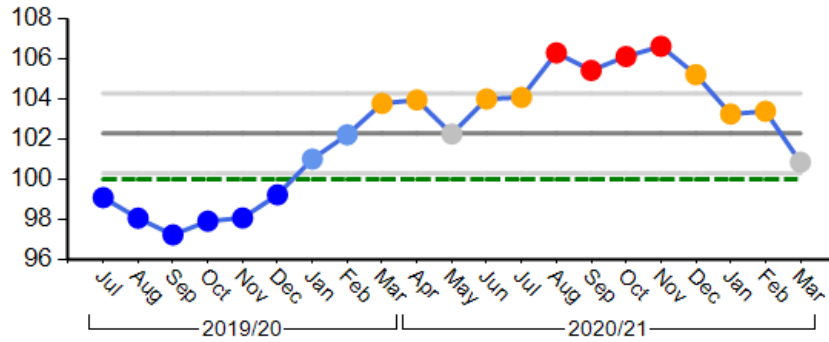
Quality

Mortality

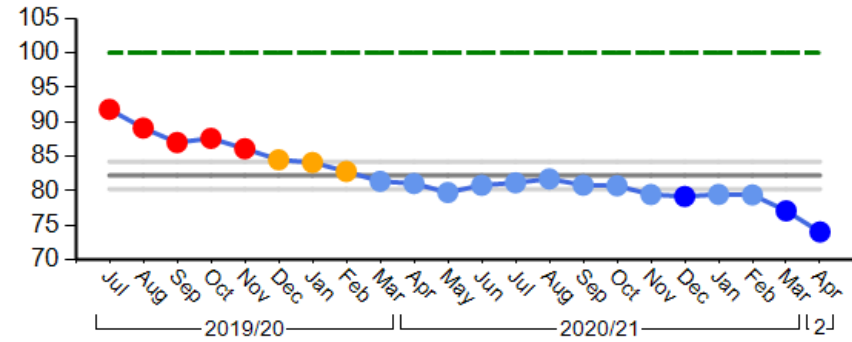
The latest SHMI, for the 12-month period ending March 2021 is 100.9. This is statistically as expected. The HES forecast is predicting Trust SHMI will drop below 100 in the next release and will still be in the 'as expected' category. This includes 6.4% of spells excluded due to Covid. The HSMR continues to show special cause improvement and continues its improving trajectory in the latest reporting month of April. Additionally, no local diagnosis SMR's are above 100 in the latest reporting period. The screening rate continues to fail its assurance measure and show special cause concern with performance in July the lowest ever recorded. The Medical Examiner's posts are expected to impact this metric in the coming months.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
SHMI (Summary Hospital-level Mortality Indicator)	100	100.9	N/A	Mar 21		100	103.4	Feb 21	100	104.3	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	74	N/A	Apr 21		100	77.1	Mar 21	100	74	
Percentage of Deaths Screened	100%	6.8%	69	Jul 21		100%	14%	Jun 21	100%	12.2%	
Perinatal Mortality Rate	5.4	5.1	5.05	Aug 21		5.4	4.2	Jul 21	5.4	2.9	

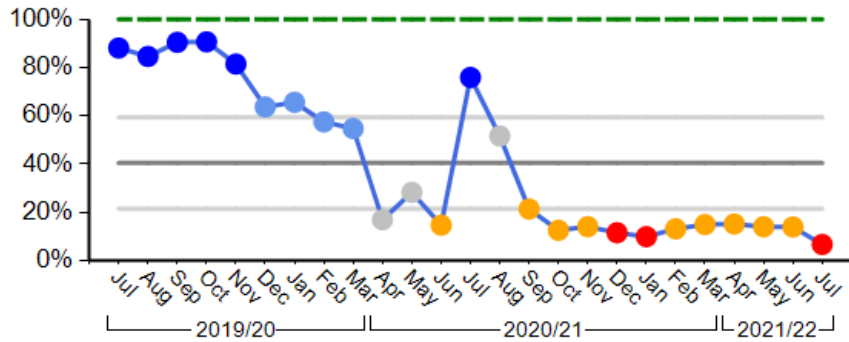
SHMI (Summary Hospital-level Mortality Indicator)



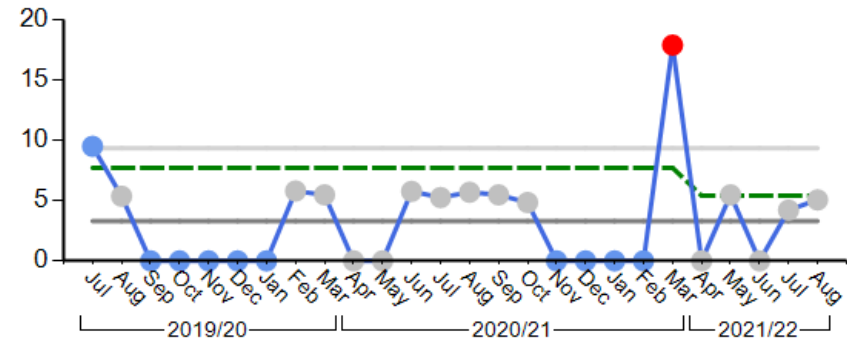
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Perinatal Mortality Rate



Patient Experience

Analyst Narrative:

Two indicators within this section are failing their assurance measure, DSSA (Delivering Same Sex Accommodation) Breaches and the Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. Assurance for the DSSA Breaches indicator has been impacted by historic performance with recent performance showing special cause improvement. The Friends and Family Test - Patients - % That Would Recommend – Trust Overall is showing special cause concern and despite an improvement in August is still significantly below both the average and target. This is against a Patient Friends and Family Test Response Rate showing positive variation and well above target. Both Duty of Candour measures continue to show positive variation, maintaining 100% performance in August.

Operational Narrative:

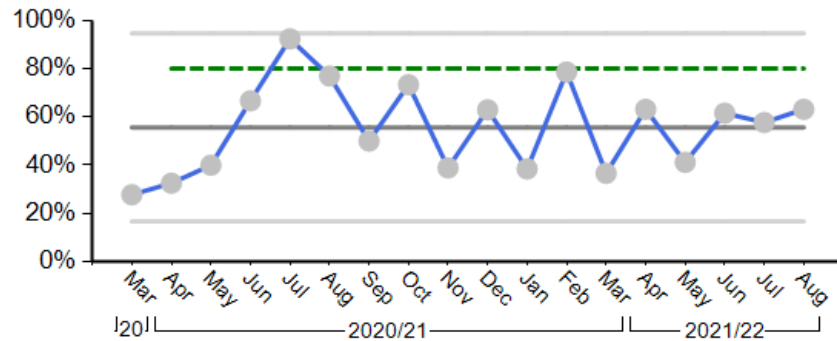
The two breaches in Delivering Same Sex Accommodation were due to delayed discharges from Critical Care. These are discussed and escalated through the 3 x daily bed meetings.

The staff survey If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation has been taken from the quarterly Pulse Survey. This replaces the Staff FFT. The Q2 Pulse Check (July 2021) shows that staff recommending the organisation for treatment has decreased 6.9%. Extensive work is underway to deliver the outcomes of the NHS People Plan with progress monitored through Workforce Improvement Group and the Valuing our People & Inclusion Group. The Pulse Check will be one way in which overall staff engagement will be tracked.

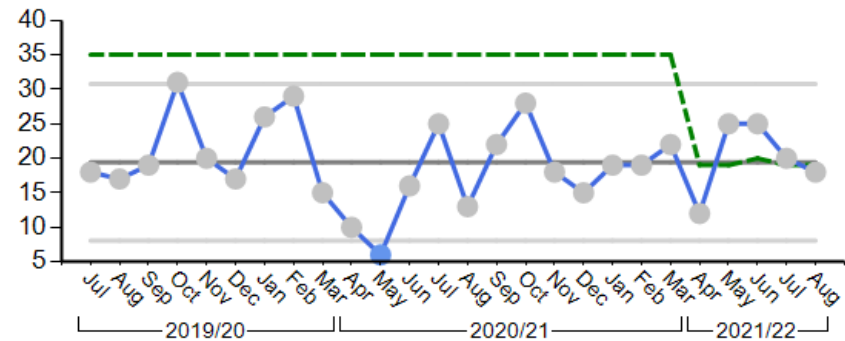
Improvements in the Patient Friends and Family metric are evident in August. This has primarily been driven by improvements within Women & Children's, where the percentage who rated the service as 'Very Good' or 'Good' has increased by 8.3% to 93% in August. Specifically, Maternity's recommend rate has increased from 77.6% to 95.2% and Paediatric A&E has increased from 86.4% to 92.4%. Smaller increases in those rating the service as 'Very Good' or 'Good' was also noted within Medicine & Emergency Care including Adults A&E. All wards achieving 100% rating for 'Very Good' or 'Good' are identified and congratulated and any wards with a higher than 10% rating for 'Very Poor' or 'Poor' are identified, with further analysis of themes and trends and local action plans put in place. An additional paper relating to Patient Experience within Medicine and Emergency Care was presented to the Patient Experience Group and Quality & Safety Committee in September.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Complaints - % closed within 40 working days	80%	63.2%	N/A	Aug 21		80%	57.7%	Jul 21	80%	57.9%	
Written Complaints	19	18	18	Aug 21		19	20	Jul 21	233	100	
Friends and Family Test - Patients - % Response Rate	15%	23%	5910	Aug 21		15%	22.1%	Jul 21	15%		
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	88.4%	204	Aug 21		94%	86.8%	Jul 21	94%	88.4%	
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	83%	51.5%	N/A	Jul 21		83%	NTR	Jun 21	83%	51.5%	
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	2	2	Aug 21		0	3	Jul 21	0	18	
Duty of Candour - Evidence of Discussion	100%	100%	0	Aug 21		100%	100%	Jul 21	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	Aug 21		100%	100%	Jul 21	100%	100%	

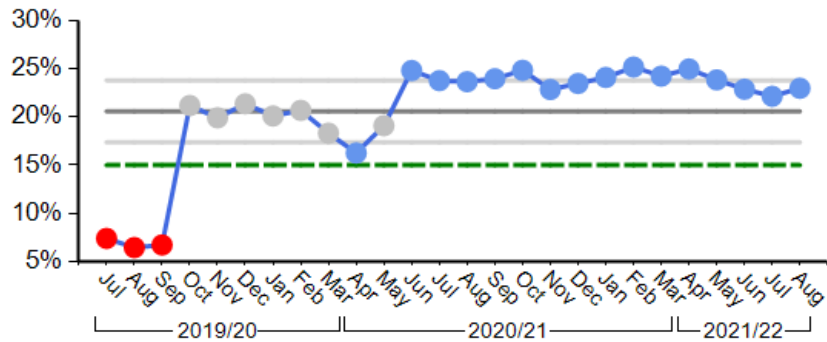
Complaints - % closed within 40 working days



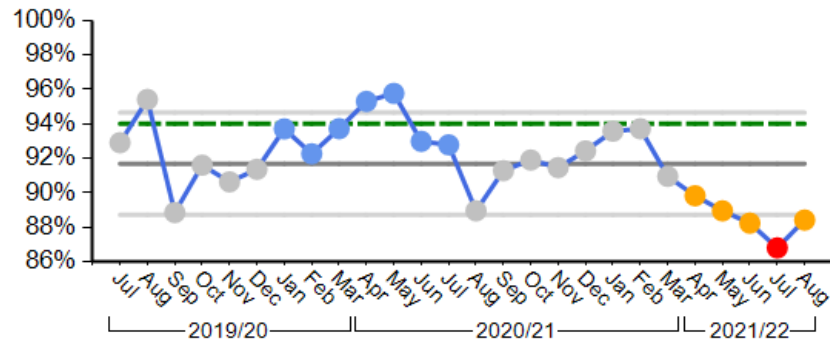
Written Complaints



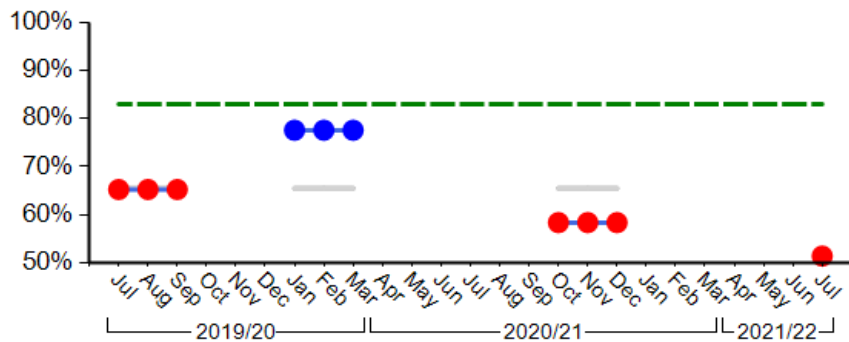
Friends and Family Test - Patients - % Response Rate



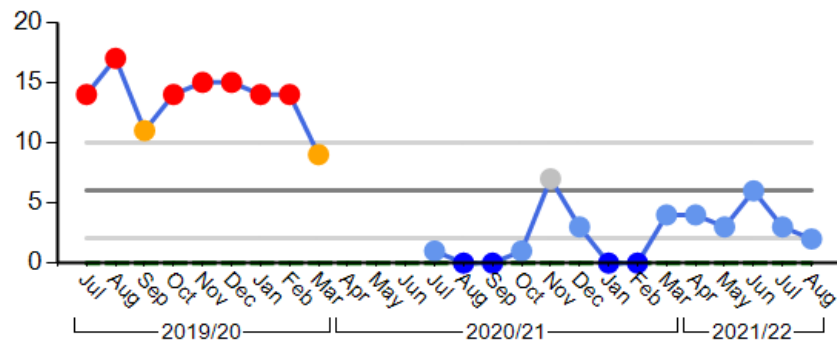
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



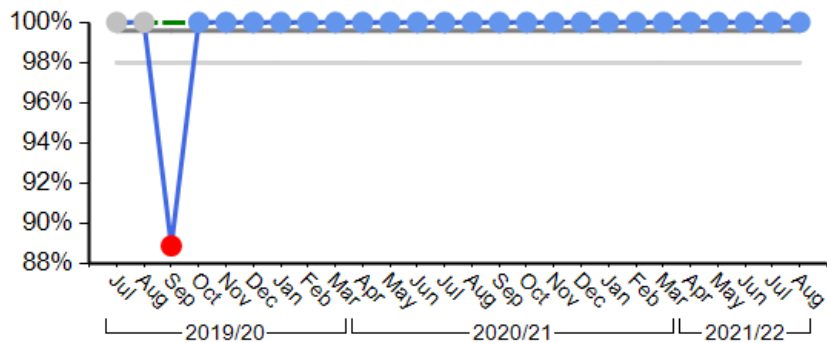
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



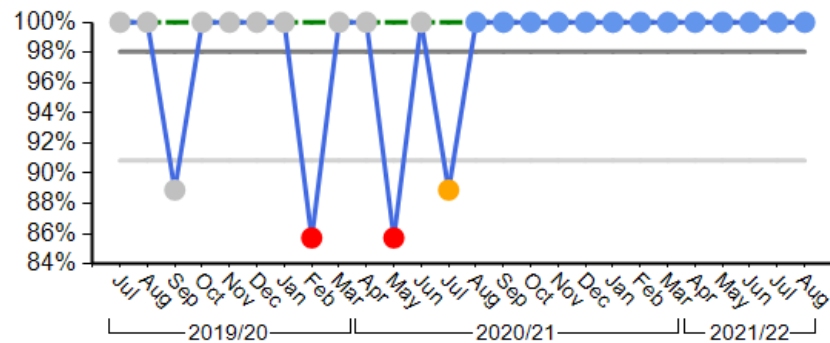
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Organisational Development

Analyst Narrative:







Personal Development Reviews continues to fail the assurance measure but has been showing special cause improvement for the last five months, with a further 2.2% increase in August. Mandatory training continues to be assured, with a further 0.9% increase in month. The results of the first quarterly Pulse Survey undertaken in July have shown a decrease in the proportion of staff who would recommend the organisation as a place to work.

Operational Narrative:

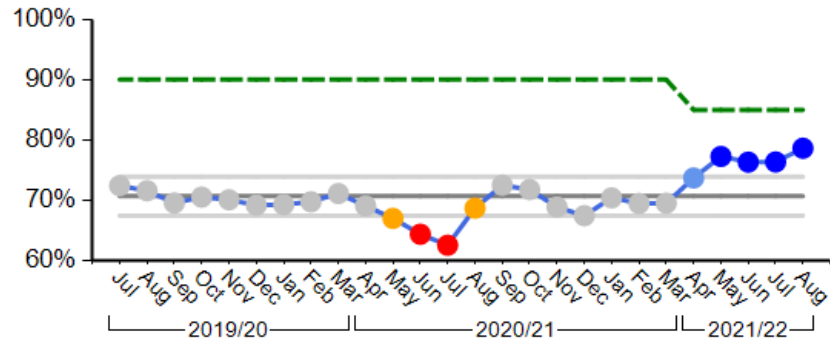
Overall mandatory training continues to provide assurance thanks to the concerted efforts of managers and staff to keep up to date. This month sees the highest % compliance achievement over the last 12 months at 88.81%, an increase of 0.88% in month. Conflict resolution remains an outlier at 73.21% with an interim solution in place for staff to access training via an online module annually in the absence of face-to-face training 3 yearly. The H&S Lead is looking to establish a more permanent solution.

Extensive work is underway to deliver the outcomes of the NHS People Plan with progress monitored through Workforce Improvement Group and the Valuing our People & Inclusion Group. The Pulse Check will be one way in which overall staff engagement will be tracked going forward.

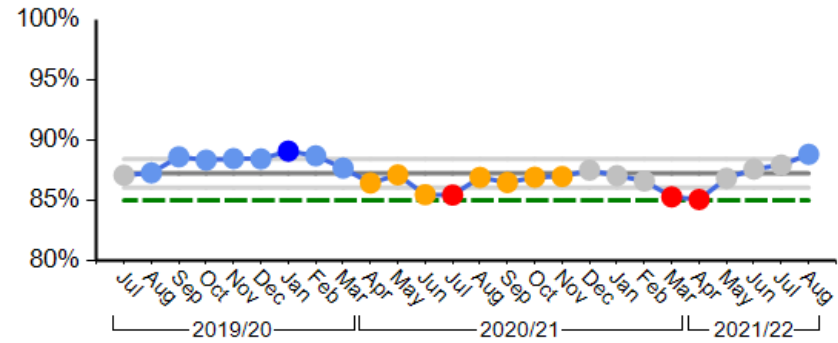
Please also see supplementary action plan for Personal Development Reviews.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Personal Development Review	85%	78.6%	N/A	Aug 21		85%	76.4%	Jul 21	85%	76.5%	
Mandatory Training	85%	88.8%	N/A	Aug 21		85%	87.9%	Jul 21	85%	87.2%	
Staff Survey - I would recommend my organisation as a place to work	67%	49.9%	N/A	Jul 21		67%	59.8%	Dec 20	67%	49.9%	

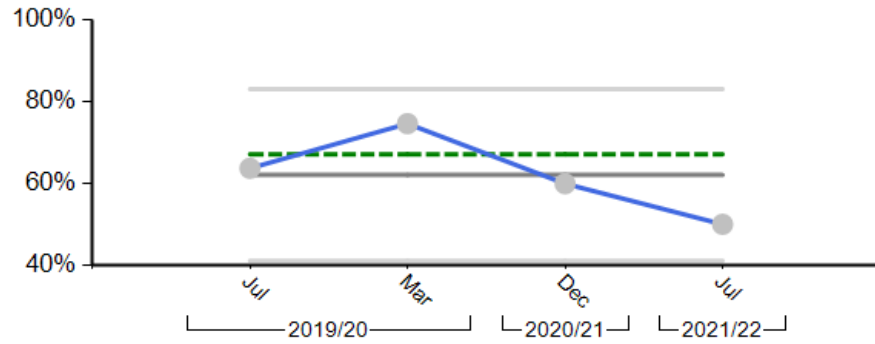
Personal Development Review



Mandatory Training

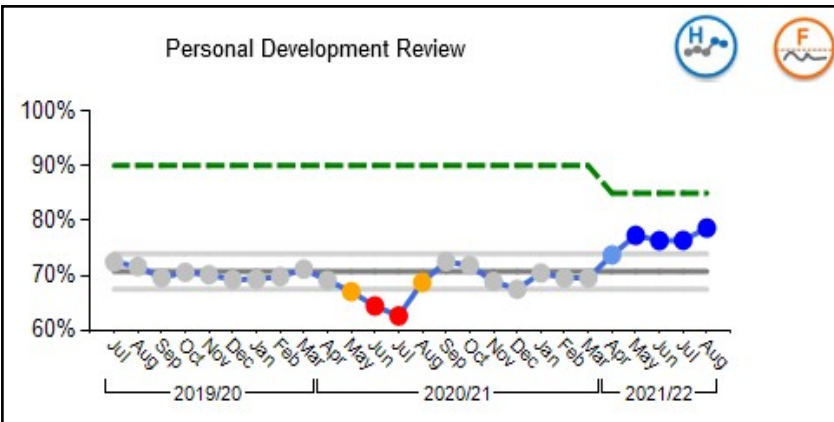


Staff Survey - I would recommend my organisation as a place to work



Non Medical Appraisal/Personal Development Reviews

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Personal Development Review	85%	78.6%	N/A	Aug 21		85%	76.4%	Jul 21	85%	76.5%	



Background: The annual appraisal/PDR is an AfC requirement for all non medical staff at the Trust and from April 2021 will be linked to pay progression. The Trust has an 85% compliance target and they form part of the Trust's performance framework and are monitored at PIDA. Appraisals are an indicator of overall staff engagement and form a crucial activity in the management of human resources.

Situation: An increased focus on compliance over the past five months has seen an increase across the Trust from 75.7% to 78.6%, which is a relatively disappointing return on the efforts made to provide CBUs and Departments with up to date data and the push for compliance. When adjustments are made for long term absence the compliance rate increases to 81.54%.

Whilst there has been an improvement in areas of services overall, the most marked improvement has been for Estates and Facilities who have improved by 22.73% with an August compliance rate of 80.65%.

Medicine and Emergency Care improved from below 70% to 83.03% and when long term absence is excluded compliance increases to 85.56%

Corporate compliance remains a concern at 63.67%

Mitigations:

PDR improvement in compliance from May to August has elicited increased compliance but there are still strides to be made. Continued focus on compliance will continue through the coming months.

Corporate compliance has increased due to the direct involvement of the HR Director.

PDR project focused on improvements for the coming year commenced during May through to late Autumn

Phase 2 of PDR project will commence in late September in relation to refreshed documentation and process

Issues:

Poor definition of the purpose of appraisals at the Trust

Poor management appraisal skills

Poor documentation and process

Lack of consistent recording impacting on the quality of data

No quality assurance mechanism in place - this has now resulted in weekly monitoring of compliance rates to improve overall performance against the Trust target of 85%

Actions:

Action plan has been developed from the Deep Dive and recent internal audit recommendations. By late Autumn 2021, the Trust should expect compliance at target

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

Sickness, Vacancy and Turnover

Analyst Narrative:

Several indicators are failing their assurance measure, in relation to Sickness, Vacancies and Turnover. The rolling 12-month Sickness rate continues to show special cause concern with a further incremental increase in August. The in-month position remains statistically as expected although well in excess of the target. Non-Covid sickness is showing special cause concern and has increased significantly over the last two months. Despite failing their assurance measure, both nursing and medical vacancies are showing special cause improvement; Medical vacancies in particular have reduced and have fallen below the target in August. Staff Turnover has increased in August, due to increases in nursing and medical turnover, but the rolling figure has reduced, although remaining well above average.

Operational Narrative:

The rise in medical staffing levels during August is excellent. This is generally a month where staffing levels significantly drop as a result of the junior doctor changeover so to close the gap in August is noteworthy. The nursing recruitment is continuing at pace and further reductions in vacancy levels will continue throughout the final months of 2021.

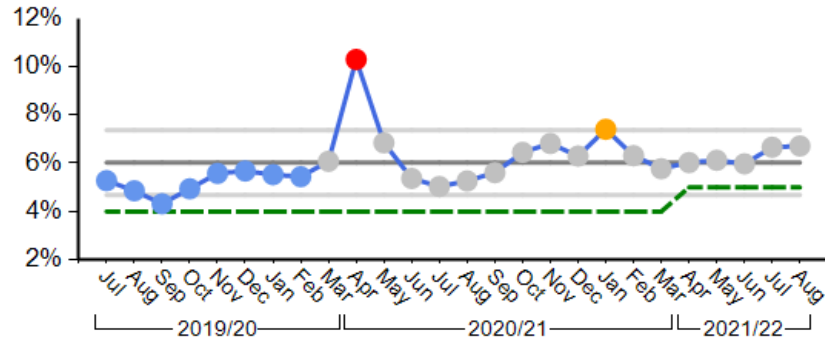
Time to recruit has increased, but mainly due to the intake of higher banded staff with longer notice periods and the expected spike in recruitment due to the medical changeover and completion of academic courses. For the year to date it sits under target and early indications for September are that it will reduce.

The staff turnover spike was anticipated but the underlying figures, when the COVID and seasonal spikes are removed remain ahead of our target.

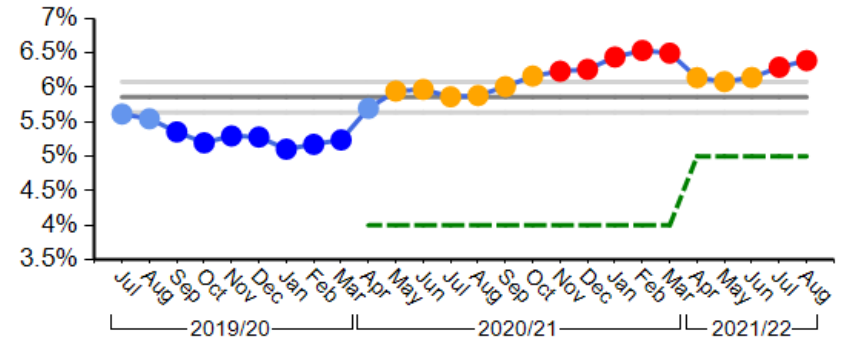
Please also see updated action plan for Sickness Absence.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Sickness Rate	5%	6.7%	N/A	Aug 21		5%	6.7%	Jul 21	5%	6.3%	
Sickness Rate (Rolling 12 Month)	5%	6.4%	N/A	Aug 21		5%	6.3%	Jul 21	5%	6.2%	
Sickness Rate - Medical Staff	5%	1.6%	N/A	Aug 21		5%	1.3%	Jul 21	5%	1.7%	
Sickness Rate - Nursing Staff	5%	9.3%	N/A	Aug 21		5%	9.1%	Jul 21	5%	8.5%	
Sickness Rate (not related to Covid 19) - Trust		6%	N/A	Aug 21			6%	Jul 21		5.7%	
Trust Vacancy Rate – All Staff	6.8%	8.8%	N/A	Aug 21		6.8%	10%	Jul 21	6.8%	9.2%	
Vacancy Rate - Medical	7.4%	6.9%	N/A	Aug 21		7.4%	8.3%	Jul 21	7.4%		
Vacancy Rate - Nursing	9%	10%	N/A	Aug 21		9%	10%	Jul 21	9%		
Staff Turnover	0.75%	1.7%	N/A	Aug 21		0.8%	1.2%	Jul 21	9%	6.8%	
Staff Turnover (Rolling)	10%	14%	N/A	Aug 21		10%	14.4%	Jul 21			
Staff Turnover - Nursing	0.8%	1.4%	N/A	Aug 21		0.8%	1.2%	Jul 21	9.6%	1.3%	
Time to Recruit	55	59	N/A	Aug 21		55	49	Jul 21	55	55	

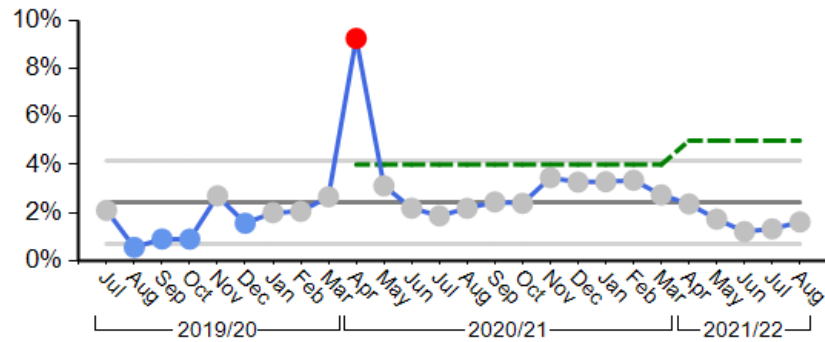
Sickness Rate



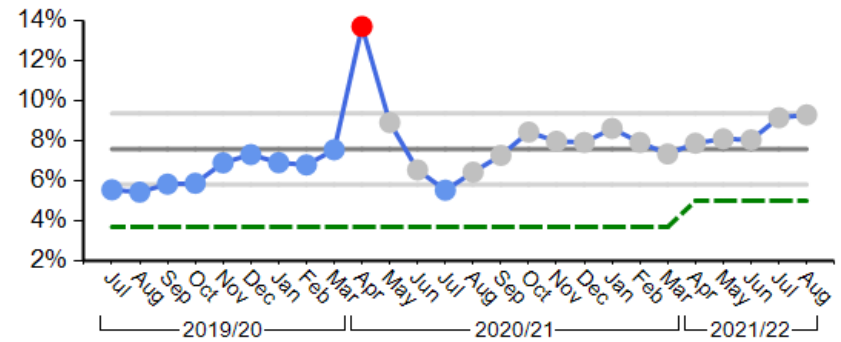
Sickness Rate (Rolling 12 Month)



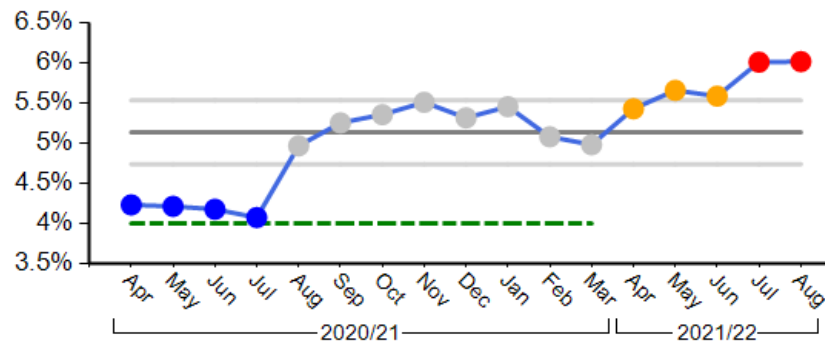
Sickness Rate - Medical Staff



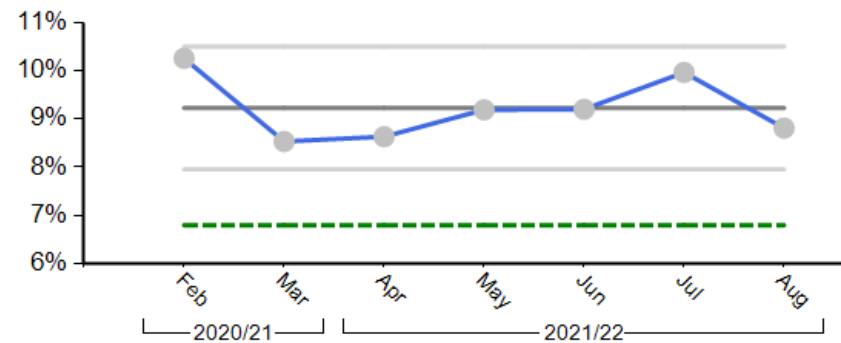
Sickness Rate - Nursing Staff



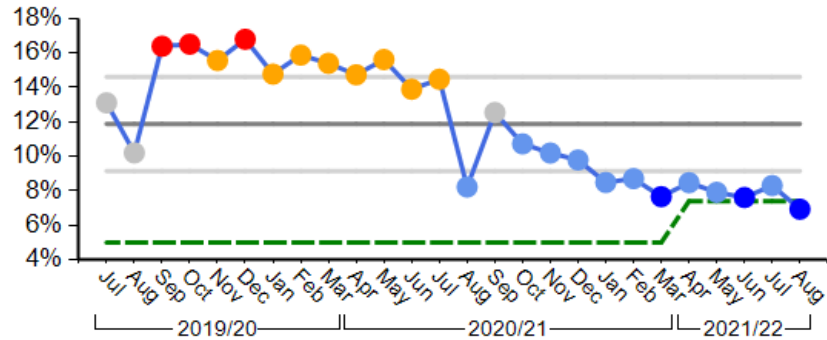
Sickness Rate (not related to Covid 19) - Trust



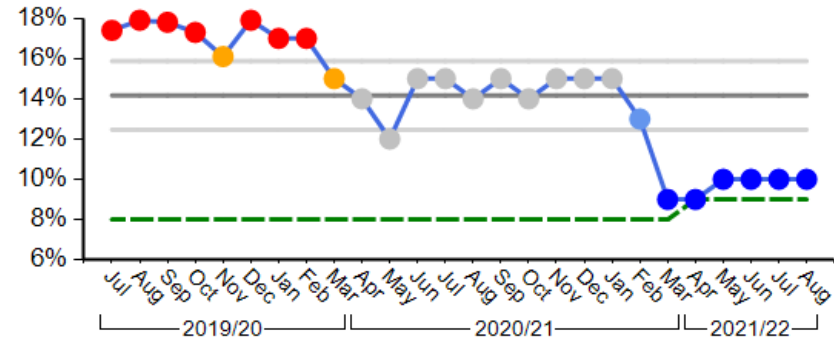
Trust Vacancy Rate – All Staff



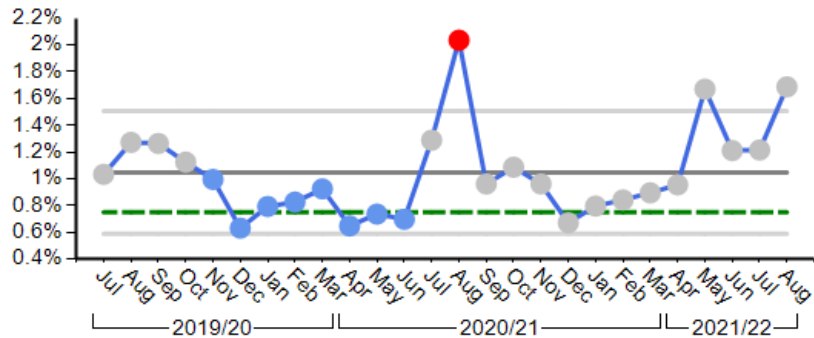
Vacancy Rate - Medical



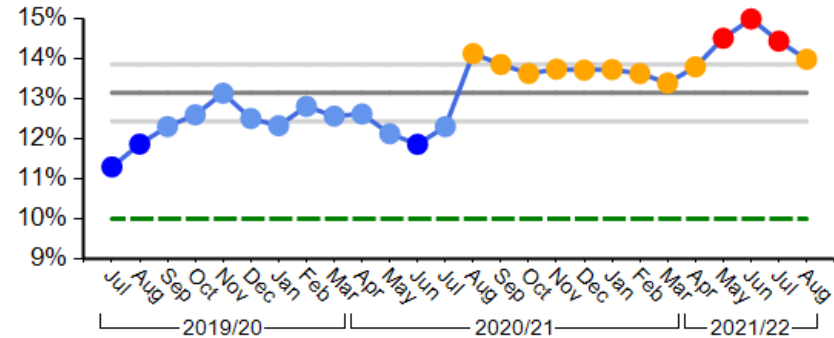
Vacancy Rate - Nursing



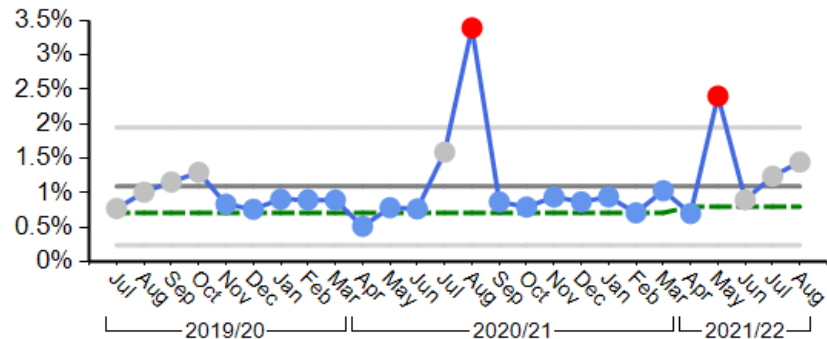
Staff Turnover



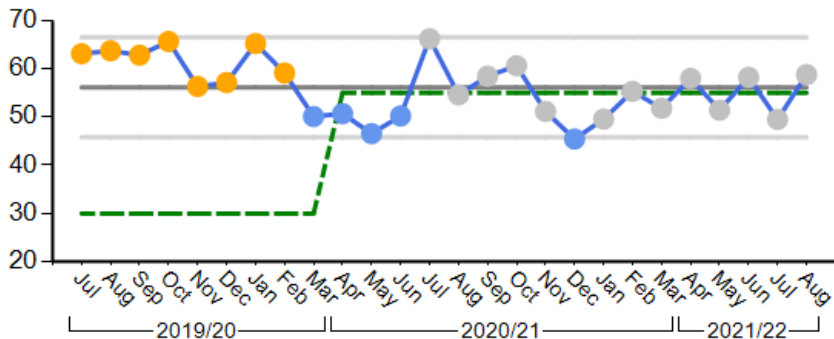
Staff Turnover (Rolling)



Staff Turnover - Nursing

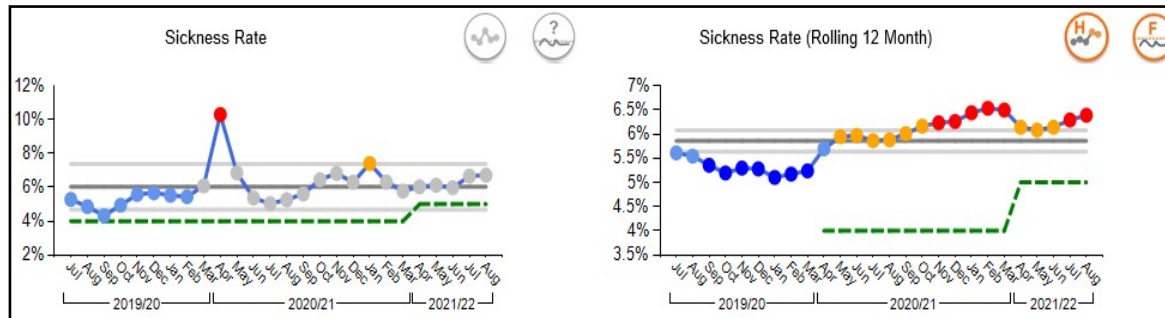


Time to Recruit



Sickness Absence

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Sickness Rate	5%	6.7%	N/A	Aug 21		5%	6.7%	Jul 21	5%	6.3%	
Sickness Rate (Rolling 12 Month)	5%	6.4%	N/A	Aug 21		5%	6.3%	Jul 21	5%	6.2%	



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. The Trust has one of the highest sickness rates compared to other Trusts in the Cheshire and Merseyside region.

Situation: As we move into the full recovery time for the trust, sickness has been relatively static but following an improvement in attendance in June, the month of July has seen a decline in attendance, primarily due to the increase of short-term absence in month. Primarily these absences relate to stress / anxiety / depression followed by other MSK and back problems. Sickness in month has not changed, remaining static at 6.7% for the Trust. Rolling 12 month absence has very slightly reduced by 0.1%. Managers and HR colleagues are still proactively working on returning people to work as well as seeking alternative ways to keep people in work.

Issues:

Long term to short term absence remains in a ratio of approximately 2:1.

Duplicate recording mostly removed from data.

E-rostering not fully rolled out to all areas as yet

Staff unaware of impact of their absence on own Department and Trust overall. Targeted work going on in CBUs and drive by HR Business Partners

Actions:

Flexible and targeted support for managers inc. 'How to' guides , HR drop in clinics and bitesize sessions on key topics

Attendance management training is now live with managers in hot spot areas being targeted to attend. Now being communicated widely through the trust. Availability of managers is being effected by the unprecedented demand placed on hospital at present time.

Flexible working policy has been reviewed and is at consultation stage

Staff engagement and communication plan focussing on the 'hearts and minds' - particularly in Planned Care

There is ongoing focus on both LTS cases and persistent short term absence.

Mitigations:

MIAA Audit undertaken October 2020

NHSE&I deep dive commenced and working closely with them in relation to emerging themes.

Operations

Access

Analyst Narrative:

Four indicators are failing their assurance measure; A&E – 4 hr compliance, Ambulance Handover 30-60 Mins, Diagnostic Waits and Referral to Treatment: on-going. The A&E 4hr hour metric is also showing recent special cause concern with performance below the third lower control limit for both July and August. Diagnostic Waits are also showing recent special cause concern with a significant decline in performance in August, to the highest % not being seen within 6 weeks since June 2020. All RTT indicators continue to show special cause concern as the Trust continues the elective recovery programme. A new indicator has been added to capture the number of patients spending 12+ hours in A&E, which is showing special cause concern due to the high demand in July and August.

Operational Narrative:

Stroke - Performance against the 90% stay on a Stroke ward continues to be challenged; long LOS in ED and site overall occupancy is hindering improvement in this area. The analysis has demonstrated delays for swabs overnight resulting in longer ED stays for stroke patients and impacting overall performance. 15B has accommodated medical and surgical outliers throughout August. The Stroke nursing team are significantly challenged due to absence at present operating a significantly reduced service; due to training required, backfill cannot be easily identified. The Lead Nurse is reviewing the team with Matron. The Stroke Improvement Group continues to focus on quality improvement in other areas. There are two key areas of focus ensuring ring fenced beds are available at all times on the stroke ward and we need to sign off the direct admission pathway from ED to stroke ward.



























TIA – a paper was presented at Medicine and Emergency care PIDA in September, detailing the current pathway and Gap Analysis. The next steps include a review of the New Model of Care and opportunities to support TIA pathway, review of the skill mix including 7 day working and review of clinic room within space utilisation project.

Accident and Emergency 4 Hour compliance – The Trust remains challenged against the 4-hour standard. The Trust experienced high demand, including primary care/walk-in type patients accounting for 75% of all attendances in August 2021. Bed occupancy at SDGH remained high, resulting in patients being bedded in A&E overnight impacted by the closure of Ward 11A and the refurbishment programme. Intermittent issues with swabs overnight have also resulted in admission delays. The Urgent and Emergency Care Improvement Group continues to meet to deliver against the workstreams identified in relation to Diagnostic Response Times, TTO's, Board/Ward Rounds, Bed Modelling, Streaming, Community Service In-reach, Medical Staffing Review, Expansion of AMU and ACU, IT Discharge System, Acute Medical On-Call, SDEC sustainability, Responsiveness and Electronic Referrals. Please also refer to the UEC Update paper. Despite the challenges, no patients received corridor care.

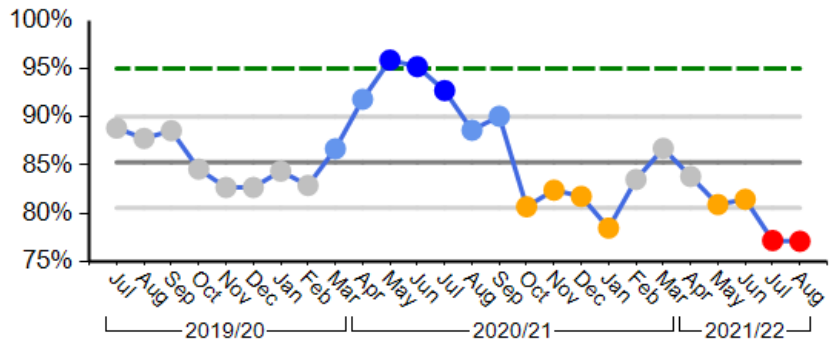
Diagnostic waiting times – There has been a further decline in performance across all modalities. This has been impacted by increased demand and changes to the urgency of requests. Capacity and demand reviews are ongoing, and the Trust has successfully recruited to an MRI Specialist Radiographer post. The Trust is also currently utilising imaging network capacity at St Helens & Knowsley, a weekly session at The Walton Centre for CT and additional capacity at Renacres for non-obstetric ultrasound. Staff are continuing to carry out additional sessions of an evening and weekend where possible. A detailed piece of work will be completed with the Directorate triumvirate to analyse and develop an improvement plan.

Endoscopy - Wait times in Endoscopy are increasing due to the demand of the 2ww waits and recent reduced/cancelled activity due to the shortage within the nursing team. The waiting list has increased by 140%, new additions has increased by 20% and Trust activity has increased by 10%. The nursing team staffing for September has improved and additional sessions can now commence within the unit. The Trust has engaged with LUFT to support for two weeks with ERCP sessions. The training plan going forward is to send over our nursing staff to LUFT to gain ERCP experience in a much quicker timescale. This will strengthen the Trust service so we can maintain the service in house. The expectation this will be by the end of October. An advert is out for six-month fixed term EDSW for the surveillance scope fit test project and the aim is to put a second candidate on reserve for the commencement of High fit. A nurse Endoscopist has been identified to contact patients to discuss Fit test results and next steps.

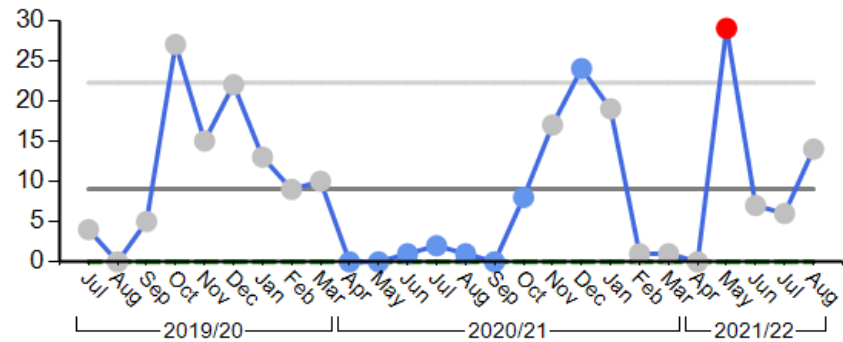
Elective restoration has been impacted in July and August by annual leave, sickness absence and the pandemic. Of the current 52+ week waiters, 31% have a TCI in place for treatment, this remains below trajectory. A paper relating to the Elective Restoration Operational Plan was taken to FP&I in September.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Accident & Emergency - 4 Hour compliance	95%	77.1%	2150	Aug 21		95%	77.2%	Jul 21	95%	80.1%	
Accident & Emergency - 12+ Hour trolley waits	0	14	14	Aug 21		0	6	Jul 21	0	56	
Number of Patients spending 12+ Hours in ED - Trust		456	N/A	Aug 21			509	Jul 21		1819	
% of Patients spending 12+ Hours in ED - Trust		6.3%	N/A	Aug 21			6.2%	Jul 21		4.7%	
Ambulance Handover 30-60 Mins	0	50	50	Aug 21		0	54	Jul 21	0	232	
Ambulance Handover Over 60 Mins	0	8	8	Aug 21		0	21	Jul 21	0	44	
Diagnostic waits	1%	34.8%	2025	Aug 21		1%	20.5%	Jul 21	1%	22.3%	
Referral to treatment: on-going	92%	83%	2137	Aug 21		92%	83.8%	Jul 21	92%	83.3%	
Total RTT Waiting List - Trust		12595	12595	Aug 21			11814	Jul 21		12595	
Total 52 week waits – completed		47	N/A	Aug 21			77	Jul 21		446	
52 Week Waits	0	132	132	Aug 21		0	101	Jul 21	0	242	
Stroke - 90% Stay on Stroke Ward	80%	65.6%	11	Jul 21		80%	69.2%	Jun 21	80%	65.1%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	15.8%	32	Jul 21		60%	34.9%	Jun 21	60%	28.3%	

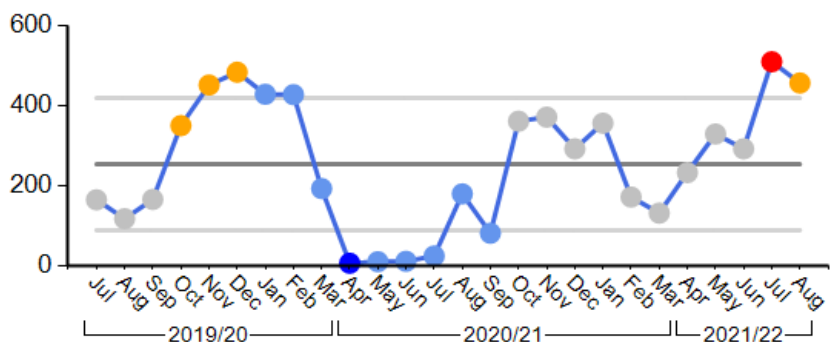
Accident & Emergency - 4 Hour compliance



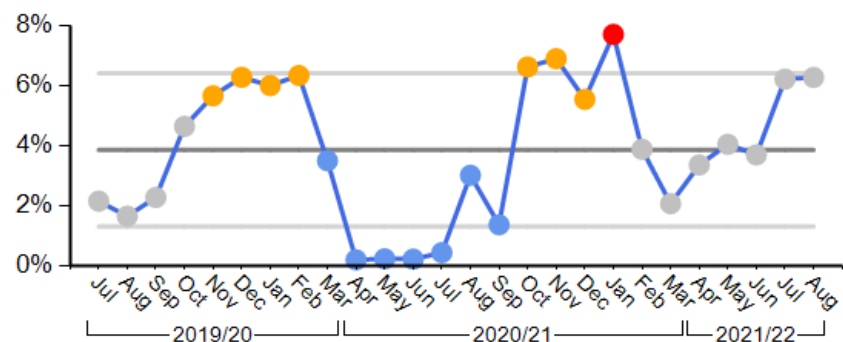
Accident & Emergency - 12+ Hour trolley waits



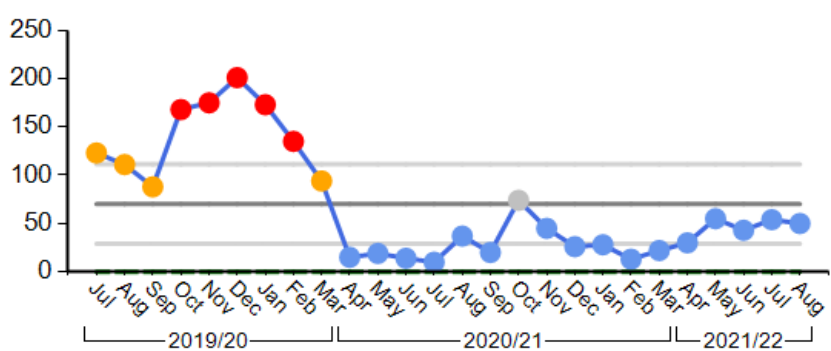
Number of Patients spending 12+ Hours in ED - Trust



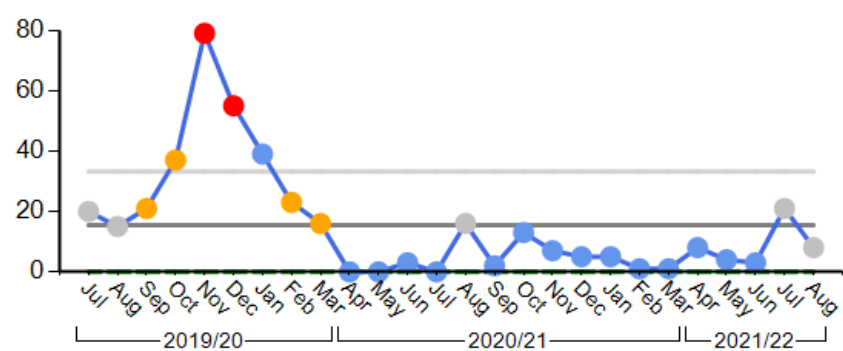
% of Patients spending 12+ Hours in ED - Trust



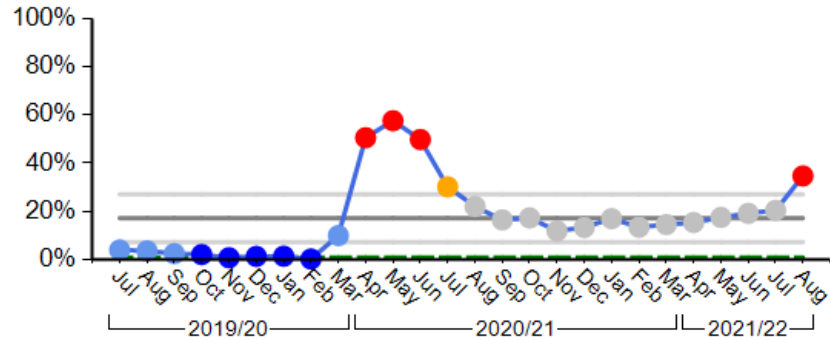
Ambulance Handover 30-60 Mins



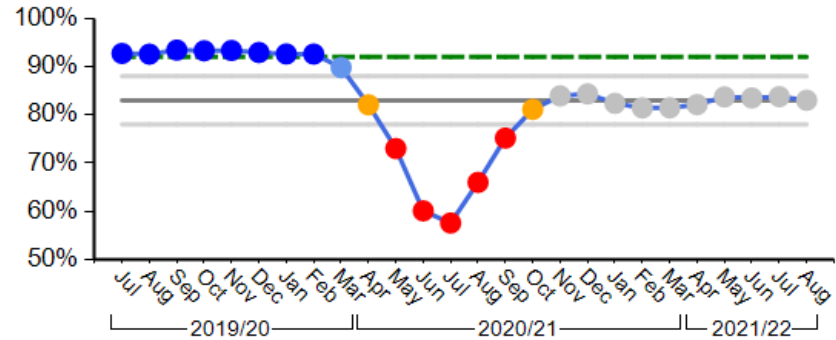
Ambulance Handover Over 60 Mins



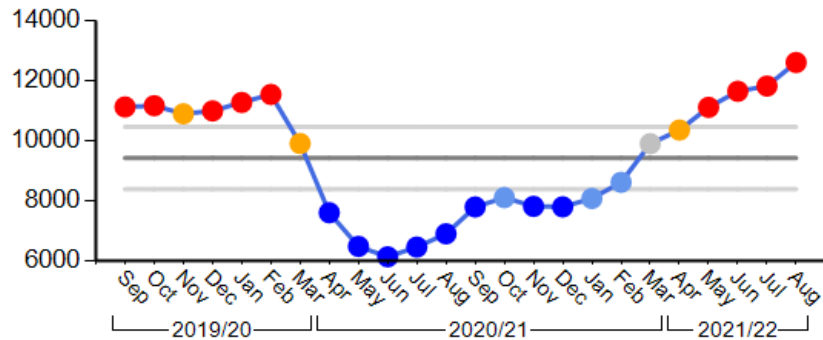
Diagnostic waits



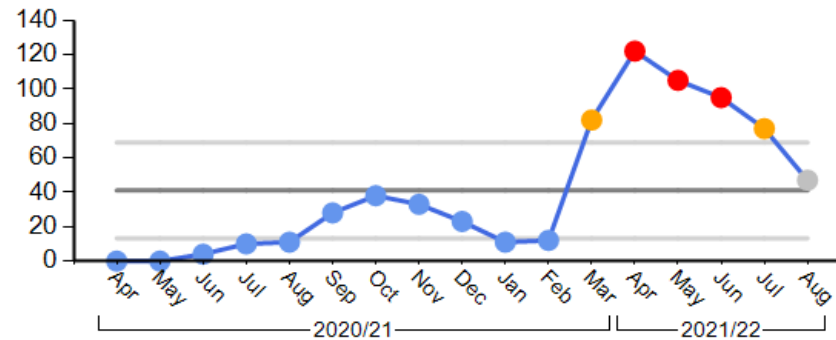
Referral to treatment: on-going



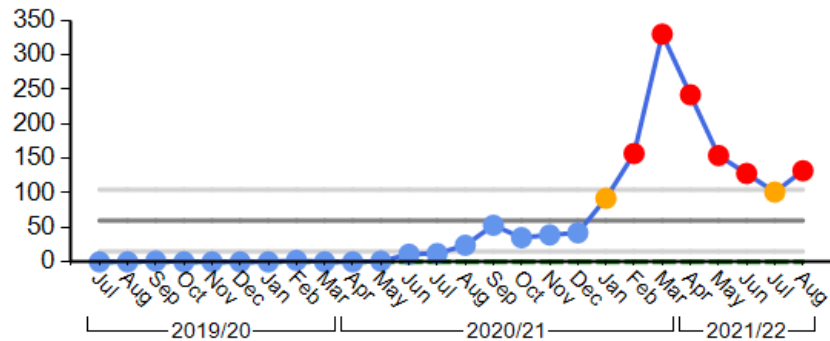
Total RTT Waiting List - Trust



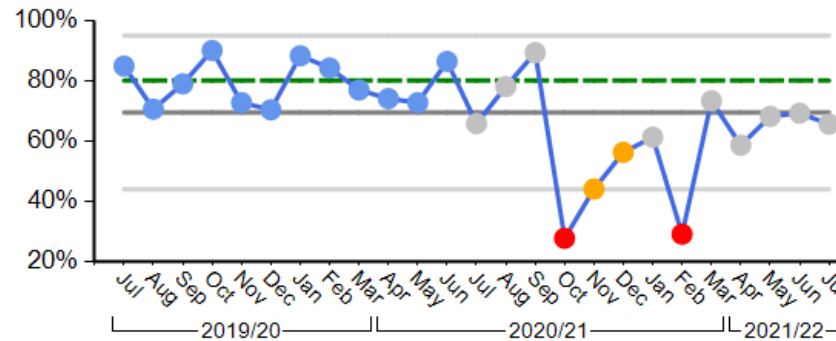
Total 52 week waits – completed



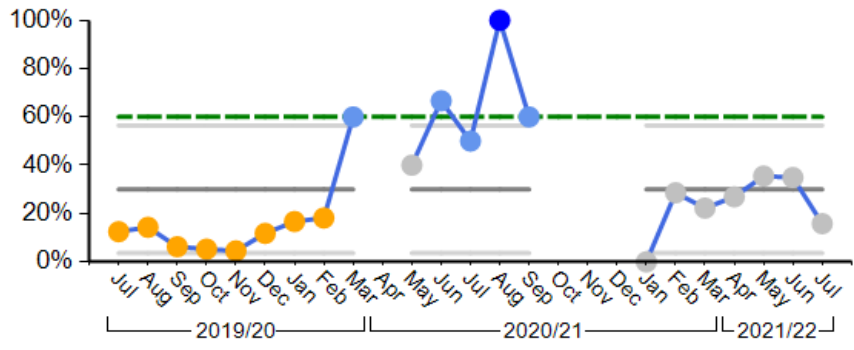
52 Week Waits



Stroke - 90% Stay on Stroke Ward



TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Operations







Cancer

Analyst Narrative:

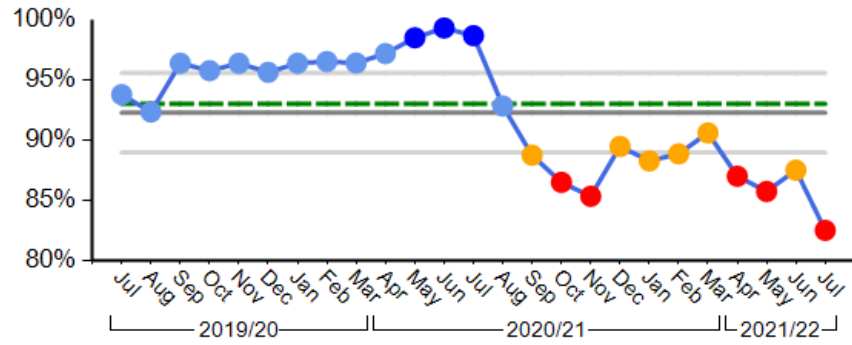
All indicators within this section are intermittent in their assurance. The 14-day GP referral to Outpatients is showing recent special cause concern and has shown a 5% decline from June to July. The 62-day GP referral to treatment is also showing special cause concern although has improved in July. The 31-day treatment metric shows special cause improvement maintaining 100% performance for three consecutive months.

Operational Narrative:

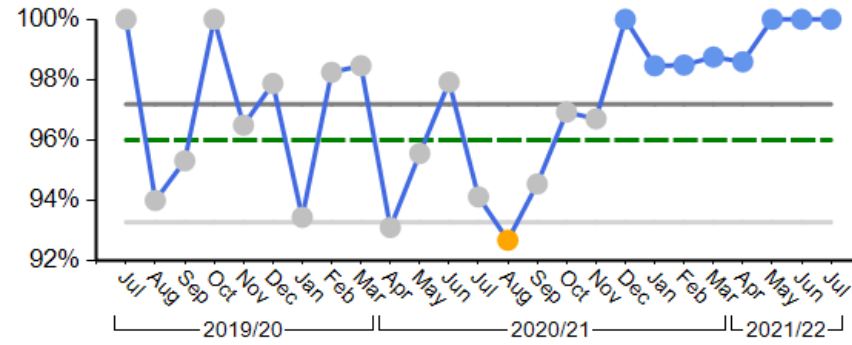
Two week wait performance continues to decline primarily due to ongoing delays accessing endoscopy services for our straight to test upper and lower GI patients. Outpatient capacity in gynaecology also continue to be a concern with not enough appointments available for the all the patients referred into the Trust within 14 days. There was a 14% increase in activity against the 62-day target. However, delays to diagnostics (endoscopy) and also significant delays receiving histology results of diagnostics have contributed to longer pathways, resulting in patients continuing to fail the target.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
14 day GP referral to Outpatients	93%	82.5%	204	Jul 21		93%	87.5%	Jun 21	93%	85.6%	
31 day treatment	96%	100%	0	Jul 21		96%	100%	Jun 21	96%	99.6%	
62 day GP referral to treatment	85%	77.1%	12	Jul 21		85%	70.7%	Jun 21	85%	73.2%	

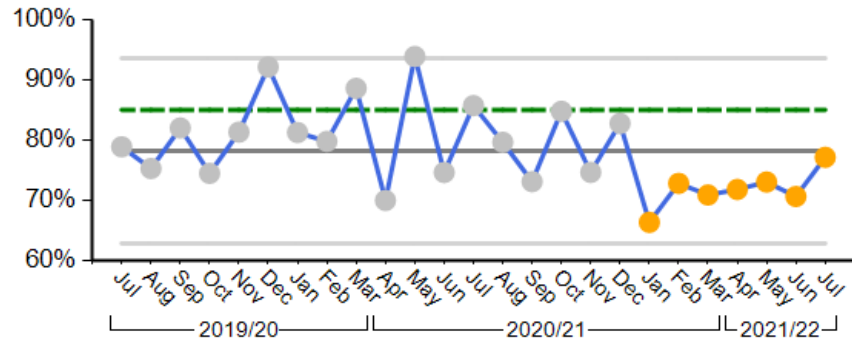
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment



Operations

Productivity

Analyst Narrative:


















The only indicator failing its assurance measure is Bed Occupancy – ODGH. Bed Occupancy – SDGH is showing special cause concern maintaining high levels in August. Several indicators are showing special cause improvement this month. Outpatient Slot Utilisation is showing special cause improvement and for the last five months has been almost or in excess of the target. Theatre Utilisation on both sites is showing special cause improvement with increases in August. Whilst the Super-Stranded patients has increased in August, it remains well below both the average and the target. The A&E Conversion rate remains static and well-below target, impacted by the high proportion of primary care/walk-in attendances. Although not statistically significant, the DNA rate has increased in month and has exceeded the Trust's stretch target.

Operational Narrative:

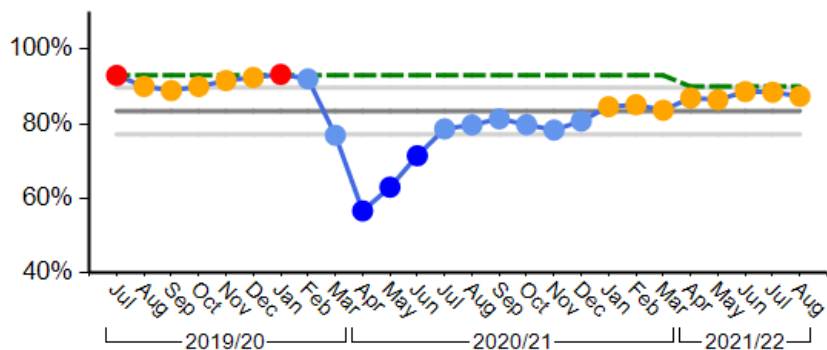
Outpatient slot Utilisation - Utilisation has dropped slightly this month from the previous month, although the Trust is still maintaining a good position. Cancellations of clinics have increased due to reg shortages and sickness which will have impacted on the filling of short notice empty slots. The Outpatient Improvement Group is well underway with the focus on PIFU and Attend anywhere.

Stranded/Super-Stranded Patients - RFD numbers fluctuating into high 50's with significant delays in S&FCCG and WLCCG for care packages; community teams report high acuity and pressure to support the numbers of FastTrack patients at home; Community beds running at near 100%. Multiple COVID breakouts in West Lancs care homes resulting in closure.

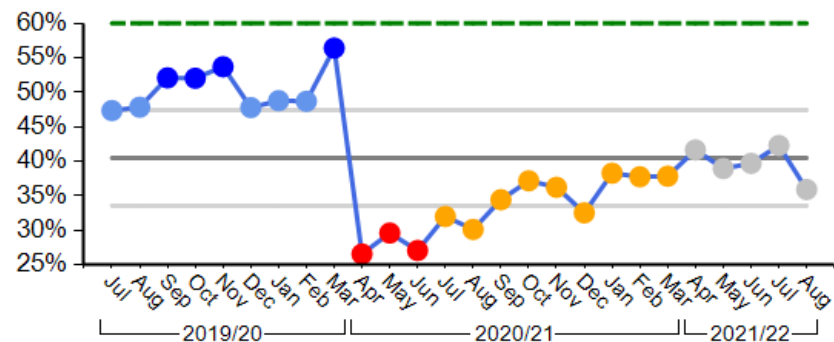
Despite decreased activity, ODGH theatre utilisation remained on upward trajectory with average cases per list in July the highest since February 2020.

Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
Bed Occupancy - SDGH	90%	87.4%	N/A	Aug 21		90%	88.5%	Jul 21	90%	87.5%	
Bed Occupancy - ODGH	60%	35.9%	N/A	Aug 21		60%	42.3%	Jul 21	60%	39.6%	
Stranded Patients (>6 Days LOS)	163	160	160	Aug 21		163	153	Jul 21	163	765	
Super Stranded Patients (>20 Days LOS)	53	46	46	Aug 21		53	42	Jul 21	53	213	
OP Slot Utilisation	95%	93.3%	N/A	Aug 21		95%	94%	Jul 21	95%	94.2%	
New:Follow Up	2.63	2.4	N/A	Aug 21		2.6	2.5	Jul 21	2.63	2.5	
DNA (Did Not Attend) rate	7%	7.1%	1435	Aug 21		7%	6.9%	Jul 21	7%	6.3%	
Theatre Utilisation - SDGH	75%	68.7%	N/A	Aug 21		75%	67.1%	Jul 21	75%	67.4%	
Theatre Utilisation - ODGH	75%	72.2%	N/A	Aug 21		75%	70.1%	Jul 21	75%	71.4%	
Southport A&E Conversion Rate	28%	21.3%	1130	Aug 21		28%	21.5%	Jul 21	28%	21.5%	

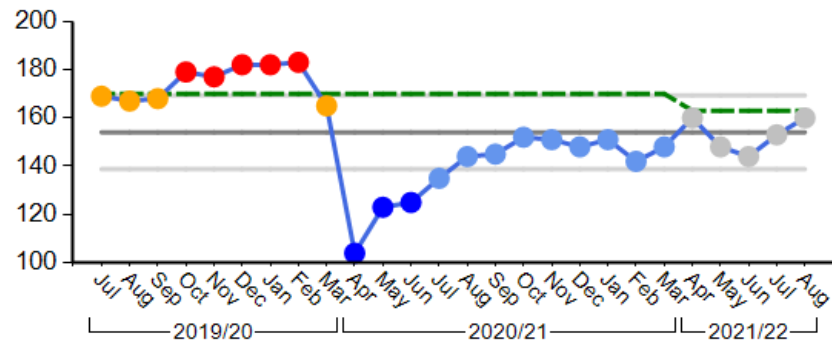
Bed Occupancy - SDGH



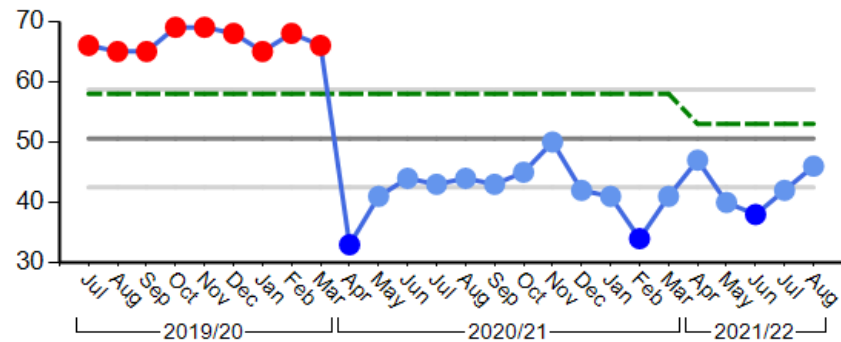
Bed Occupancy - ODGH



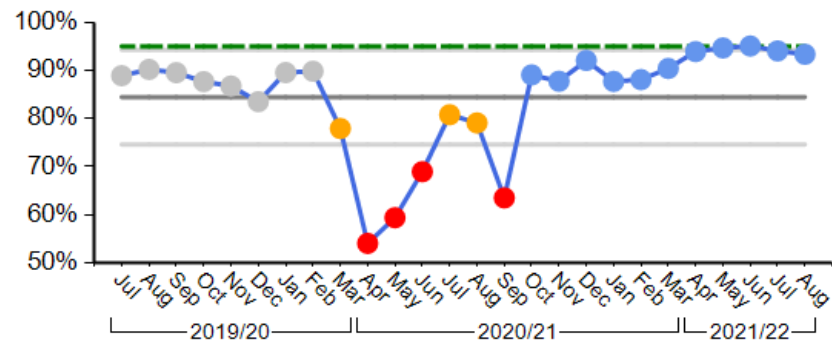
Stranded Patients (>6 Days LOS)



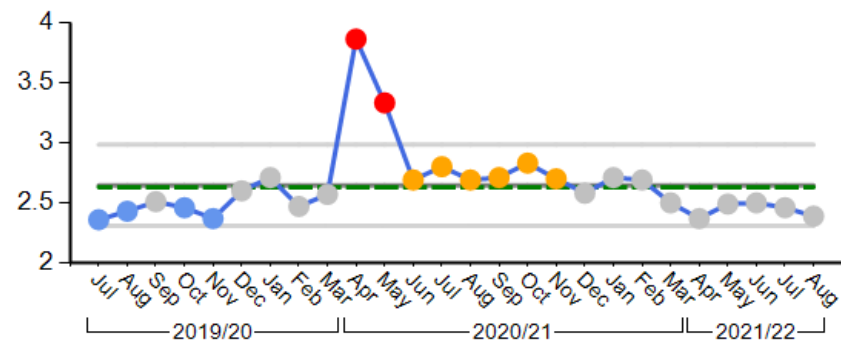
Super Stranded Patients (>20 Days LOS)



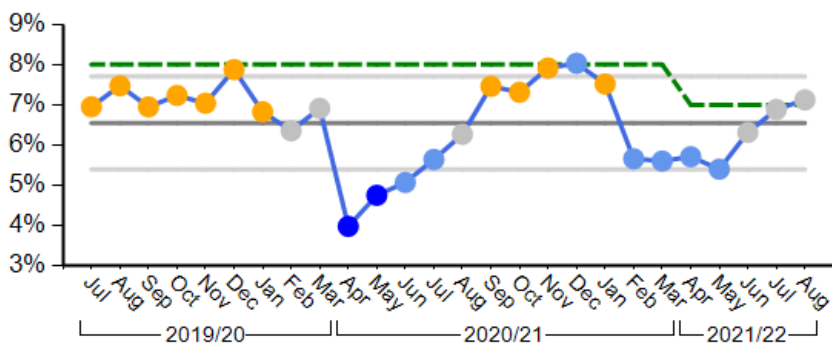
OP Slot Utilisation



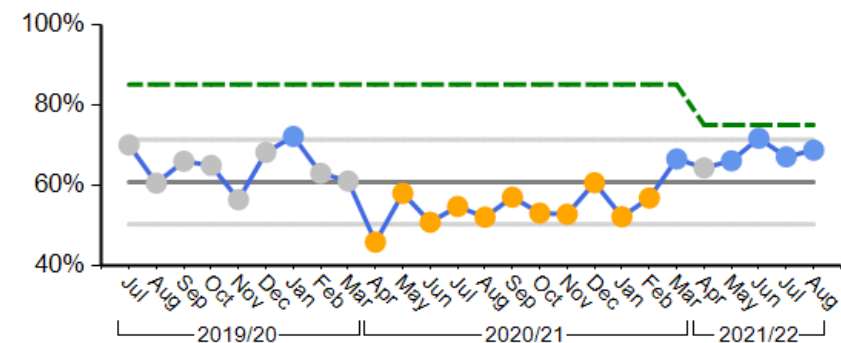
New:Follow Up



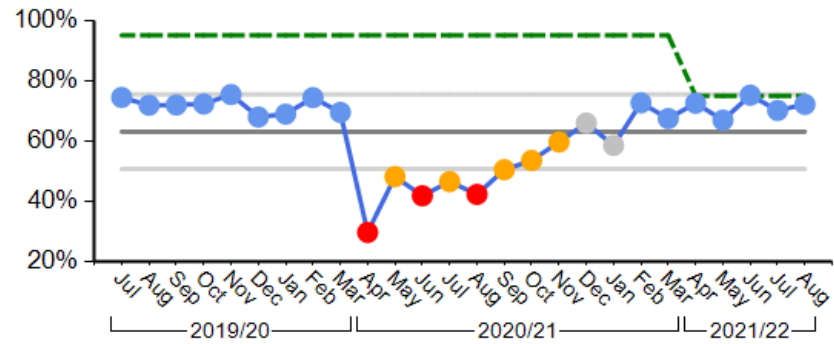
DNA (Did Not Attend) rate



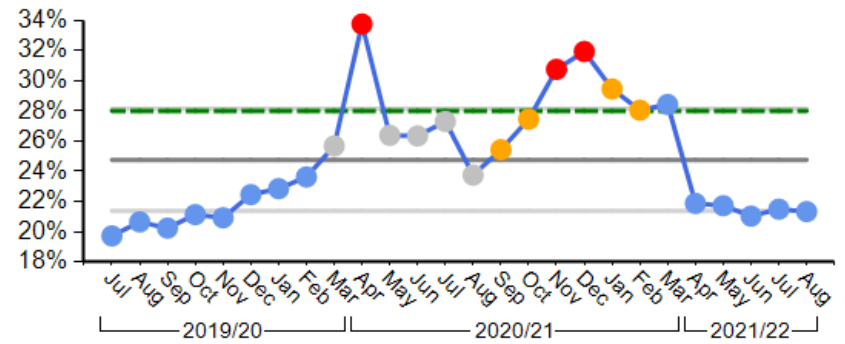
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate



Finance

Analyst Narrative:

Several indicators are showing special cause improvement. I&E surplus or deficit/total revenue has declined in month and is below plan but remains above average. The Agency Staff Run Rate (Costs) and % Agency Staff (cost) are also showing positive variation with significant reductions in August. The Pay Run Rate continues to show special cause concern although performance remains fairly static.

Operational Narrative:

The Trust is required to break-even for the first half of the financial year ('H1')

Delivery of the H1 financial plan required a £3.7m CIP and relied upon a £0.8m contribution from Elective Recovery Funding (ERF).

The financial run rate has remained broadly consistent prior to month 5, with pressures being experienced as a result of slippage against H1 CIP plans and continued premium rate staffing costs.

In addition, planned monthly Elective Recovery Funding (ERF) of £358,000 has reduced to £nil from month 5 following changes to ERF income thresholds as previously reported.







At Month 5, the Trust has therefore delivered services at a £751,000 cumulative deficit, however is forecasting delivery of a break-even financial position for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed ICS funding.

Medicine & Emergency Care CBU continues to incur significant premium rate expenditure across nursing and medical staffing. A review is required to understand the drivers of continued overspends on premium rate staffing in the CBU, and the steps being taken in order to deliver an improvement to the current expenditure trajectory.

Financial pressures are anticipated through the remainder of the 2021/22 financial year into H2 arising from:

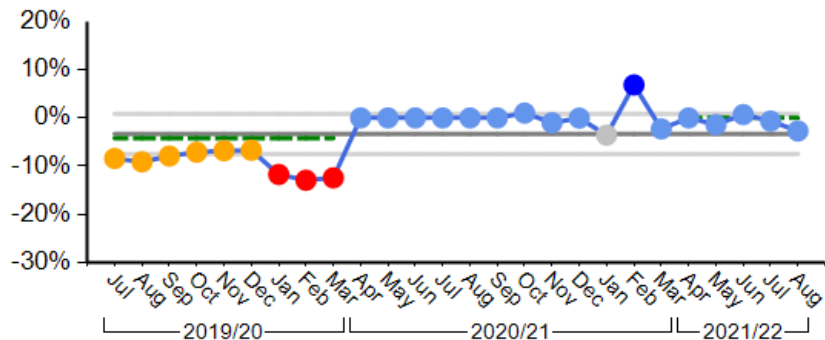
- Slippage against CIP plans
- Operational impact of easing of Covid restrictions coupled with early winter pressures
- Delivery of elective recovery in the context of the above
- Changes to Elective Recovery Funding (ERF) income thresholds

Based on the current financial trajectory, pending national planning guidance and system ability to deliver ERF funding for the remainder of the financial year, the Trust is anticipating a requirement for external support funding during H2. The current route for cash support is to apply for DHSC revenue support loans.

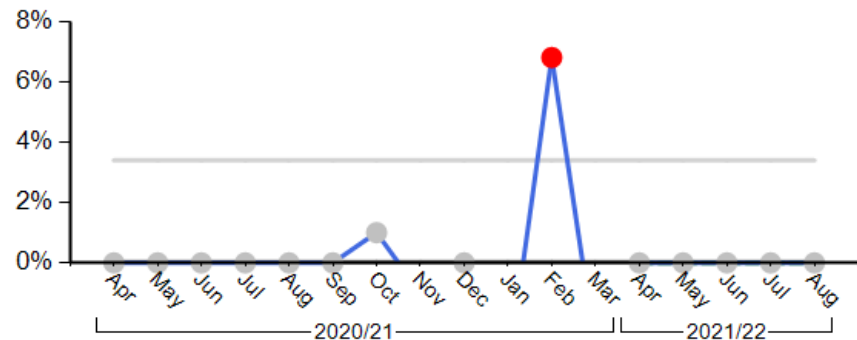
Indicator	Latest					Previous			Year to Date		Assurance
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	
I&E surplus or deficit/total revenue	0%	-2.7%	N/A	Aug 21		0%	-0.7%	Jul 21	0%	-0.86%	
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	0%	N/A	Aug 21		0%	0%	Jul 21	0%	0%	
Pay Run Rate - Trust	£13,400K	£13328K	N/A	Aug 21		£13,300K	£13280K	Jul 21	£66,900K	£67,029K	

Non Pay Run Rate - Trust	£6,000K	£6160K	N/A	Aug 21		£6,000K	£6112K	Jul 21	£29,670K	£29,720K	
Year to date Budget in balance		No	N/A	Aug 21			No	Jul 21		No	
Budget in balance - forecast year end		Yes	N/A	Aug 21			Yes	Jul 21		Yes	
Bank & Agency Run Rate - Trust		£2411K	N/A	Aug 21			£2203K	Jul 21		£11,113K	
Bank & Agency Staff Run Rate (%)		18.1%	N/A	Aug 21			16.6%	Jul 21		16.6%	
Agency Staff Run Rate (Cost)		£650K	N/A	Aug 21			£800K	Jul 21		£4,050K	
% Agency Staff (cost)		4.9%	N/A	Aug 21			6.3%	Jul 21	5%	6%	
Year To Date Reduction in Premium Rate pay		£200K	N/A	Aug 21			£200K	Jul 21		-£100K	
CIP – Performance against Plan	£600K	£500K	N/A	Aug 21		£600K	£500K	Jul 21	£3,090K	£1,400K	
CIP – Forecast Outturn	£7,400K	£4400K	N/A	Aug 21		£7,400K	£4400K	Jul 21	£7,400K	£4,400K	
CIP on Target		No	N/A	Aug 21			No	Jul 21		No	
Capital Spend – Actual in Month	£500K	£200K	N/A	Aug 21		£900K	£200K	Jul 21	£2,900K	£800K	
Capital Spend – Forecast Outturn		£6900K	N/A	Aug 21		£6,900K	£6900K	Jul 21			
Cash Balance		£3400K	N/A	Aug 21		£4,700K	£5100K	Jul 21			

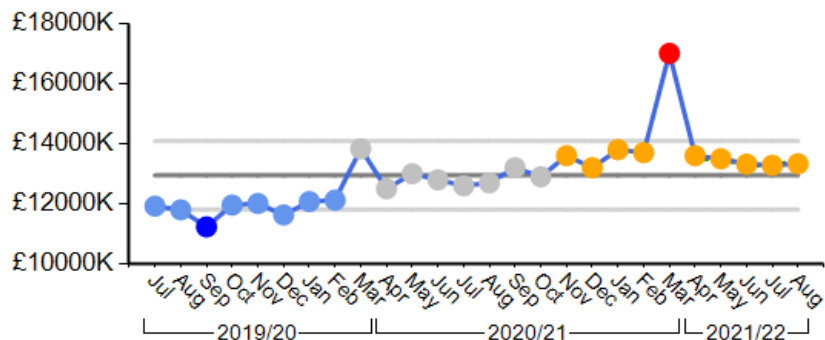
I&E surplus or deficit/total revenue



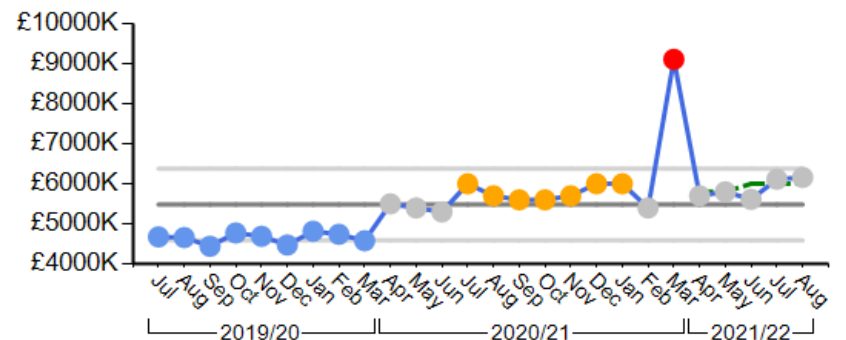
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



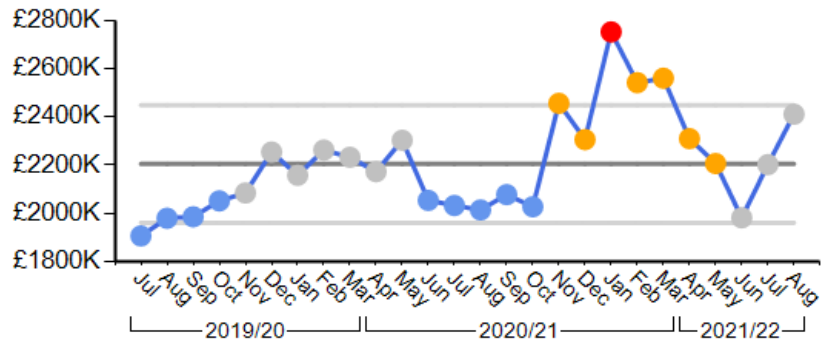
Pay Run Rate - Trust



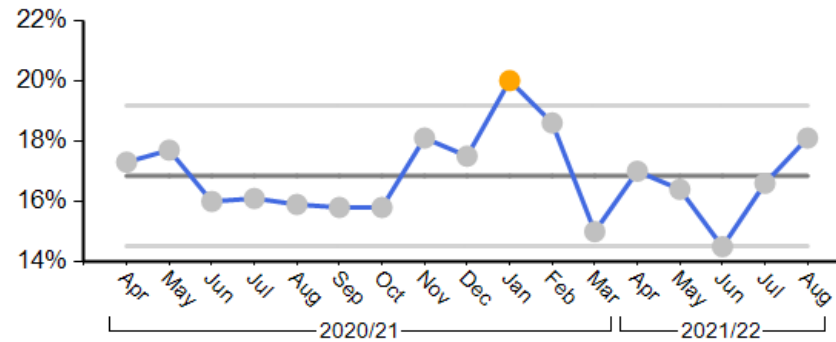
Non Pay Run Rate - Trust



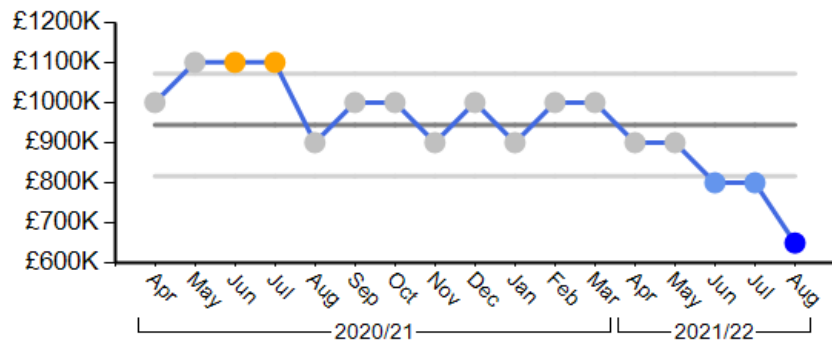
Bank & Agency Run Rate - Trust



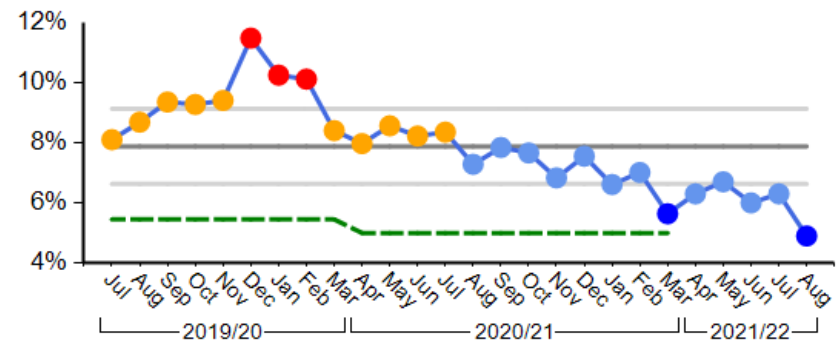
Bank & Agency Staff Run Rate (%)



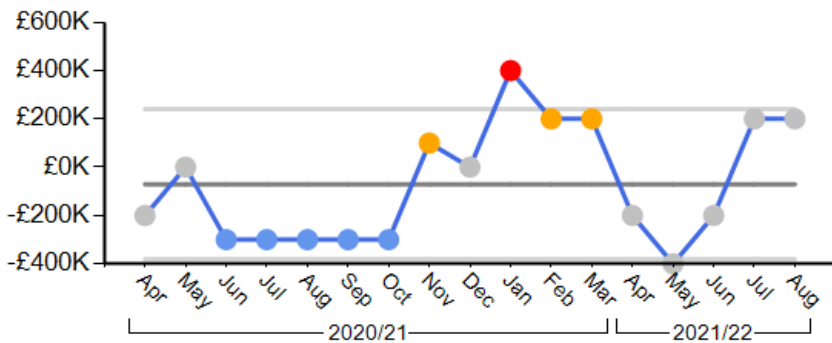
Agency Staff Run Rate (Cost)



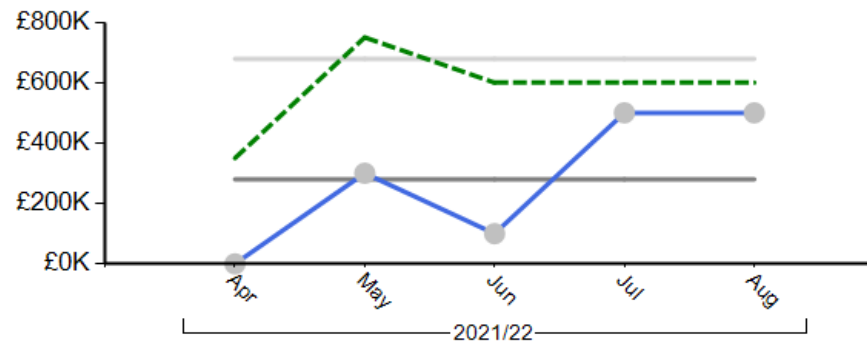
% Agency Staff (cost)



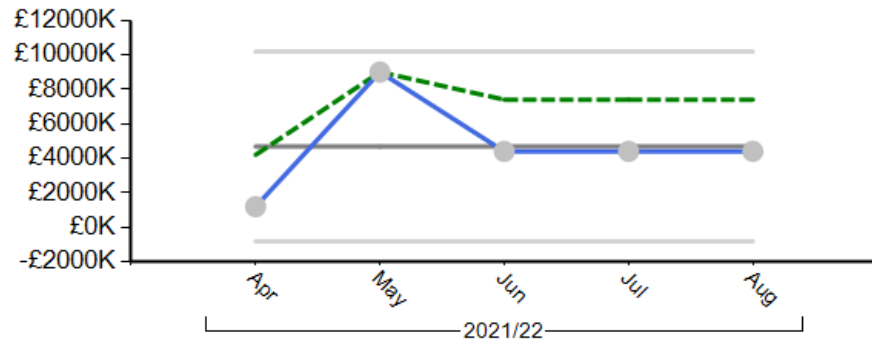
Year To Date Reduction in Premium Rate pay



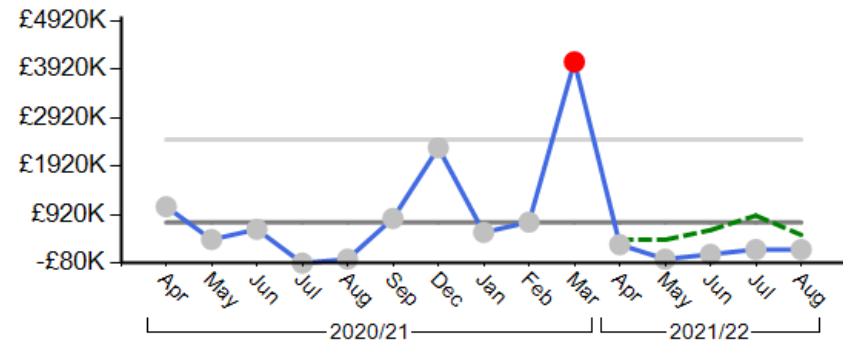
CIP – Performance against Plan



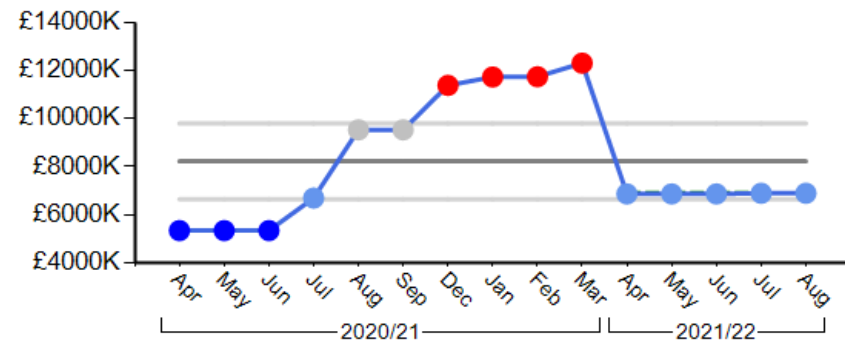
CIP – Forecast Outturn



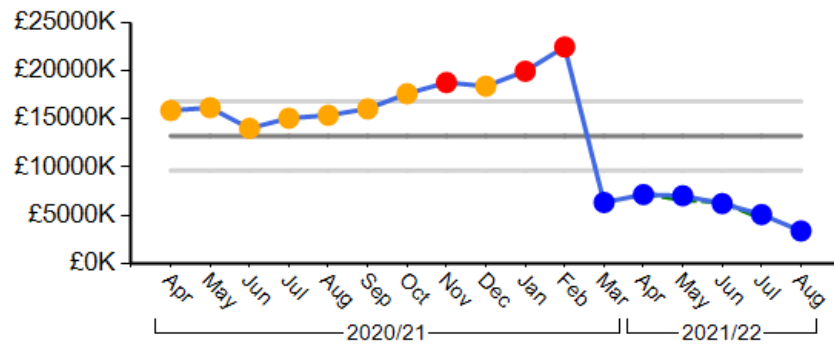
Capital Spend – Actual in Month



Capital Spend – Forecast Outturn



Cash Balance



ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	27 SEPTEMBER 2021
LEAD:	GILL BROWN

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Annual Report: Resuscitation – the service requires further resources to ensure all Quality Standards (UK Resuscitation Council) are met.

ADVISE

- Fragile Services Update: comprehensive presentation received. No immediate quality or patient safety concerns and progress with some services eg Radiology. Focus is now on prioritisation of the most fragile services and collaboration with StHK.
- Waiting List Update - Risk stratification and Clinical Harm Reviews: The Committee requested a further report focusing on and providing more detail for lost to follow up and clinical harm reviews. MBI Healthcare Technologies have provided the Trust with external assurance regarding the systems now being used to monitor waiting lists.
- Safe Nursing & Midwifery Staffing: This biannual report provided a comprehensive update on staffing Nov 2020 to June 2021 for nursing, midwifery and AHPs. Over the period Staffing 90.1% (Standard is >90) and CHPPD 9.25 (Standard is >7). The report included details of the Trust's innovative and tenacious approach to recruitment, including overseas candidates. There remain several band 5 RN vacancies although a positive forecast is anticipated. Challenges, as detailed in other Committee reports, remain in most clinical teams, especially sickness absence. HR support is being provided.
- Safe Staffing failed to achieve 90% target for the last two months. Figures are reflective of issues related to the pandemic, annual leave and sickness; however mitigations are in place. The positive impact of recruitment initiatives are expected to be seen by November 2021.
- Core Mandatory Essential Skills Compliance: A report was received detailing improvement work, including the Clinical Competency Working Group (CCWG). The majority of training compliance has improved but unfortunately others have deteriorated. Ability to achieve compliance is reflective of the pandemic.
- Annual Report: Integrated Governance – CAS alert (Estates & Facilities) and Enforcement notices: Outstanding actions remain regarding testing of fire and smoke dampers and ensuring integrity of fire stopping in some wards.
- Falls Update: report received regarding current numbers of falls and continuing falls prevention work which are a Quality Priority for 21/22.
- Serious Incidents Q1 21/22: Women's and Children Services have had the highest number of serious incidents during 21/22 Q1. This is a high risk area for the Trust and external scrutiny is provided by Healthcare Safety Investigation Branch (HSIB) and completion of the Perinatal Mortality Review Tool (PMRT).

- Pulse Staff Survey: decline noted in this quarterly report regarding a standard of care for friends / relative question. Relatively small number of responses compared to annual Staff Survey. HR team currently assessing the data.
- Three breaches of 1:1 care in Maternity: These are related to staffing pressures and high levels of acuity. Pressures related to maternity staffing are also being seen in other trusts in the Cheshire & Mersey region.
- C Diff Infection Rates: concern noted regarding numbers and trajectory. The Trust is reviewing processes along with external support. Update report will be presented to the Committee next month.
- Learning from Deaths: 6.8% deaths screened. Medical Examiners recruited and a plan is in place to improve compliance and provide assurance. Triangulation with mortality data will also support assurance.

ASSURE

- Covid-19 Update & Winter Planning: comprehensive verbal updates received from DoN and MD regarding current Covid-19 status and winter planning arrangements.
- CQC Update: Update received with most actions completed or progressing on schedule. Actions from the unannounced focused inspection (March 2021) also included. A monthly dashboard is currently being developed for future updates.
- Short Stay Therapy Model: exemplar presentation delivered by Sharon Saunders, Advanced Occupational Therapist, describing the successful implementation of a step down rehabilitation facility to support patient flow during the pandemic. The model involves system collaboration with local CCGs and nursing homes.
- Infection Prevention and Control Assurance Framework: All actions completed or progressing on schedule.
- Annual Report: Patient Safety: Comprehensive report received. Focus for 21/22 is 10 areas agreed by the newly established Quality Improvement Board.
- Annual Report: Safeguarding: Comprehensive report received. An important focus for 21/22 is to plan and prepare for implementation of Liberty Protection Safeguards process. Inclusion of case studies reiterates work undertaken by staff to safeguard our patients and is to be commended.
- Annual Report: Safety of Medicines & Controlled Drugs: Assurances provided together with recommendations for 21/22.
- Medical & Emergency Care FFT Performance: the report details actions taken to improve patient experience.
- (1) Maternity Report & (2) Induction of Labour (IoL) Audit: (1) Report provided assurance regarding workforce, Safe Care, Personalised Care, & Safer Births. (2) Audit presentation provided an excellent example of clinical audit and where the Trust can make improvements.

New Risk identified at the meeting

- No new risks were identified at the meeting.

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)

Title of Meeting	STRATEGIC & OPERATIONS COMMITTEE	Date	06 October 2021
Agenda Item	SO006/21	FOI Exempt	NO
Report Title	INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Andrew Chalmers, Consultant Nurse/Deputy Director - Infection Prevention & Control		
Action Required	<input type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input checked="" type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
This report provides the Committee with an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Assurance Framework			
Executive Summary			
<p>The IPC BAF was first reported to the S&O Trust Board in July 2020 and has been presented to the Quality & Safety Committee and Board on a monthly basis.</p> <p>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.</p> <p>In this month's review of the IPC BAF actions, a further action has now changed from green to blue with respect to Respiratory Protective Equipment as it is evident through the audits of PPE that the Trust is complying to the IPC guidelines. There are now three actions that remain green and require further progress:</p> <ul style="list-style-type: none"> • Within action 1 there is the issue with assessing and verifying appropriate ventilation in clinical areas – this has entailed a technical piece of work to find out what the air flow and air exchanges are in rooms across the Trust. This process is nearing completion and the report will soon be available, at which stage recommendations will be agreed if any improvements are required. • Also within action 1 is the requirement for employees to complete IPC annual training at level 2 – this keeps on nearing the target of 85% (82.48% in August), hence further encouragement is in process for all staff to be up to date with their mandatory training. • The final green action is action 10 which acknowledges that even though staff movement between wards is minimised that due to current vacancies this is not always attainable. The Trust is actively recruiting additional staff to minimise this risk as well as ensuring that staff aren't moved mid-shift. <p>Progress</p> <p>IPC audits and mandatory training continues to be monitored:</p> <ol style="list-style-type: none"> 1. Hand Hygiene Audits - Trust compliance August 2021 (94.8%) ↑ above target 2. PPE Compliance Audits - Trust compliance August 2021 (96.3%) ↑ above target 3. IPC Mandatory Training - Compliance – <ol style="list-style-type: none"> a. Level 1 August 2021 (92.66%) ↓ above target 			

- b. Level 2 training August 2021 **(82.48%)** ↑ below target
4. Visiting guidance is now linked with the Priority Area COVID Level Triggers to provide consistency across the Trust which had led to the restarting of visiting in the NWRSIU, however this wasn't expanded as the triggers then increased requiring only limited visiting in special circumstances.

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.
- The ventilation task and finish group is to review and make recommendations once the assessment has been completed by the ventilation engineers and a report produced.
- The visiting process needs further review to make it more user friendly for patients and relatives – this is currently being evaluated by the patient experience Matron.

Recommendations

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

Previously Considered By:

- | | |
|--|--|
| <input type="checkbox"/> Finance, Performance & Investment Committee | <input checked="" type="checkbox"/> Quality & Safety Committee |
| <input type="checkbox"/> Remuneration & Nominations Committee | <input type="checkbox"/> Workforce Committee |
| <input type="checkbox"/> Charitable Funds Committee | <input type="checkbox"/> 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:

Andrew Chalmers

Presented By:

Bridget Lees

Infection prevention and control board assurance framework

June 30th, 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 (August 21)	New BRAG Rating (September 21)
<ul style="list-style-type: none"> • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff. • the documented risk assessment includes: <ul style="list-style-type: none"> ○ a review of the effectiveness of the ventilation in the area. ○ operational capacity. ○ prevalence of infection/variants of concern in the local area. 	<ul style="list-style-type: none"> • Monthly ventilation meetings to review current guidance Deputy DIPC and estates, next meeting 29/9/21 • Estates to update IPC Bronze meeting 23/7/2021 – Audit completed on 1989 side of SFDGH, 14s and 15s ward templates to be completed then move onto ODGH • IPC & estates meet monthly • Prevalence of infection/variants of concern in the local area are communicated via PHE/CCG at IPC Bronze meetings • Ventilation authorized person is in place and is coordinating audit of current ventilation status across the two hospital sites and is producing a report • Comms sent out on Monday 16/8/21 with respect to IPC including ventilation and room capacity/social distancing 	<ul style="list-style-type: none"> • Ward areas need own Risk Assessment, Estates currently in process, BMS Contracting assessing all areas both sites. Expected completion date SDGH 13/8/21. To then start at ODGH 16/8/21. Update from Estates 15/9/21 is that the results from testing are being collated and the report with suggestions from the Ventilation Authorised Person will soon be available for the task and finish group to review and make recommendations. 	<ul style="list-style-type: none"> • Once ventilation reports are received any recommendations will be reviewed and actioned if appropriate • Advice taken from PHE/CCG regarding variants and impact to Hospital reviewed and actions put in place if required • Guidance provided to all areas re ventilation, room capacity and social distancing • Daily IPC visits to wards to promote compliance 	New KLOE from July 2021	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (August 21)	New BRAG Rating (September 21)
	<ul style="list-style-type: none"> On Friday 13/8/21 IPC presented to Trust Brief Live and included guidance on appropriate ventilation, room capacity and social distancing 				
<ul style="list-style-type: none"> Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways. <p style="text-align: center;">No outstanding actions – all complete</p>					
<ul style="list-style-type: none"> when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; 	<ul style="list-style-type: none"> Covid-19: Guidance for maintaining services within health and care settings published 1st June 2021 – guidance taken and changes to PPE communicated via Trust news and given to all clinical areas by IPCT Team to staff with pictures and examples 17/06/2021. If a clinician identifies an increased risk, then extended use of PPE maybe recommended and put in place; this is communicated and discussed with IPC team and Microbiologist IPC team available 7 days a week and Microbiologist on-call 	None		New KLOE from July 21	
<ul style="list-style-type: none"> resources are in place to enable compliance and monitoring of IPC practice including: <ul style="list-style-type: none"> patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care 	<ul style="list-style-type: none"> 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) RPE in use in compliance with COVID-19 guidance for maintaining services within healthcare settings June 2021 V 1.2 The IPC team audit compliance through the Perfect Ward app, IPC Audit for each 	<ul style="list-style-type: none"> None 		New KLOE from July 21	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (August 21)	New BRAG Rating (September 21)
<p>and are wearing appropriate PPE:</p>	<p>ward – this is a new audit that has just been introduced; early results confirm that 100% of mobile in-patients wear a mask</p> <ul style="list-style-type: none"> • Visiting is currently restricted. All visitors are required to wear PPE and are symptom checked • Visiting guidance is in line with Priority Area Covid level Triggers which was presented to CRG 20/07/2021 • Visiting guidance compliance with IPC practice is advertised on posters around the hospital site, social media, Trust website 				
<ul style="list-style-type: none"> • training in IPC standard infection control and transmission-based precautions are provided to all staff 	<ul style="list-style-type: none"> • IPC Mandatory Training - Compliance – Level 1 August 2021(92.66%) – Target achieved. • Level 2 training July 2021 (82.48%) – just below target; and a small increase on previous month (80.20%) • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • Online You Tube training • Comms sent out on Monday 16/8/21 with respect to IPC including PPE, COVID screens, hand hygiene, employee LAMP testing, ventilation and room capacity/social distancing • On Friday 13/8/21 IPC presented to Trust Brief Live and included guidance on PPE, COVID screens, hand hygiene, 	<p>Not reached 85% target for Level 2 IPC training in August 2021</p>	<p>Monthly training compliance report is circulated to CBUs monthly and managers/supervisors reminding staff of mandatory training</p> <p>Frequent reminders re IPC best practice circulated in Trust News.</p> <p>Information re IPC provided to staff at safety huddles</p> <p>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.</p>		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (August 21)	New BRAG Rating (September 21)
	employee LAMP testing, ventilation and room capacity/social distancing				

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					
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (August 21)	New BRAG Rating (September 21)
<p>• Implementation of the supporting excellence in infection prevention and control behaviours implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)</p>	<ul style="list-style-type: none"> • Toolkit has been considered and some points put in place or already in use for example: - • Staff work force – flexible working from home were appropriate • Staff encouraged to take staggered breaks to allow social distancing – messages from Matrons, IPC team, Trust brief • Cleaning- ‘I’m clean’ notice/stickers been embedded in practice for minimum 5 years • Estates-heated marquee was in place – Estates are now looking at a permanent fixture • Leadership – faceless sickness line for staff via HWB, where possible meetings have been moved to virtual via Teams • Use of posters with Trust staff used to promote PPE • Patient posters used to inform patients of the actions they can do to stay safe • Information/banners on work computers and intranet • IPC link workers in clinical areas 	None	None	New KLOE from July 21	

	<ul style="list-style-type: none"> • Trust Facebook page for staff “meeting place” • Trust brief live every Thursday – Teams meeting with Execs with access by all staff • Temperature and symptom check on patients coming into outpatients and for visitors 				
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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

No outstanding Actions – all complete

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

No outstanding Actions – all complete

7. Provide or secure adequate isolation facilities

No outstanding Actions – all complete

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

No outstanding Actions – all complete

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 (August 21)	New BRAG Rating (September 21)
<ul style="list-style-type: none"> consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance 	<ul style="list-style-type: none"> There is a general principle that staff are not moved between wards unless there is an urgent need (cover wards). In general staff should remain where they are allocated The Trust continues to actively recruit staff and has been successful in recruiting a number of nursing staff from overseas which helps to reduce the need for movement of staff due to the added numbers 	Movement of ward staff to cover shifts (Safe Staffing)	If reallocation required this is advised to occur at the start of shifts to decrease the risk of cross contamination		

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

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 October 2021
Agenda Item	SO006/21	FOI Exempt	NO
Report Title	SAFE NURSING AND MIDWIFERY STAFFING REPORT		
Executive Lead	Bridget Lees - Director of Nursing, Midwifery and Allied Health Professionals		
Lead Officer	Lynne Barnes - Deputy Director of Nursing, Midwifery and Allied Health Professionals Carol Fowler - Assistant Director of Nursing Workforce		
Action Required	<input type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
<p>This report provides the Strategy and Operations Committee with a comprehensive update on staffing for nursing and midwifery, and for the first time includes an Allied Health Professional (AHP) update. The update will focus predominantly on the inpatient bed base areas and includes an overview of the current staffing position and the developments taken to ensure staffing levels are safe and sustainable.</p>			
Executive Summary			
<p>This bi-annual report provides information around safe nurse/midwifery/AHP staffing between November 2020 and June 2021 inclusive. This is aligned to the planned cycle of bi-annual staffing establishment reviews for the Trust however slightly extended in its reporting timeframe to allow for the most updated position following the last review presented to Workforce Committee and Trust Board in February 2021 (reportable period May to October 2020). A high-level summary of the paper is as follows:</p> <ul style="list-style-type: none"> • The UNIFY safe staffing reported for the cycle – average 90.1% • Care Hours per Patient Day (CHPPD) reported for the cycle – average 9.25 • Trust overall Band 5 Registered Nurse (RN) vacancies is 96 whole time equivalent (WTE) an improved position on 107 (WTE) vacancies in November 2020 and with a positive trajectory (zero RN vacancy by Q4) due to the international nurse recruitment programme • There are no band 4 vacancies to report from current establishment reviews • The Trust band 2 & 3 Healthcare Assistant (HCA) vacancy for inpatient areas in June reports zero vacancies • AHP vacancy update and plan to recruit • Positive engagement and growth of advanced roles across the CBU's with further planned • Update regarding apprenticeship opportunities with growth planned • Proactive engagement with HEI's – Project to increase placement capacity for pre-registration nursing and midwifery student numbers by 50% • Skill-mix outcomes within current budgeted establishment to support development roles into the nursing workforce including leadership opportunities at ward level and training/education roles which are vital in supporting our recruitment and retention plans • Staffing reviews completed for ED and inpatient areas • Staffing review outcomes that will require investment • Successful bids from regional and national funding – NNU and Midwifery • An update regarding spend and agency reduction • International recruitment progress and trajectory • Continued challenges with sickness levels and the interventions in place 			

Recommendations	
The Committee is asked to receive the report and support the direction of travel currently being taken particularly in relation to safe staffing, recruitment and ongoing establishment reviews.	
Previously Considered By:	
<input type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee	<input checked="" type="checkbox"/> Quality & Safety Committee <input checked="" type="checkbox"/> Workforce Committee <input type="checkbox"/> 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	
<input type="checkbox"/> SO5 Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
<input type="checkbox"/> 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:
Carol Fowler, Assistant Director of Nursing & CBU ADNs and Lynne Barnes – Deputy Director of Nursing Midwifery and Allied Health Professionals.	Bridget Lees – Director of Nursing, Midwifery and Allied Health Professionals.

1. Purpose

This report provides the committee with a comprehensive update on the staffing situation for nursing, midwifery and Allied Health Professionals (AHPs). For nursing and midwifery, the review mainly focuses within the inpatient bed base areas and includes an overview of the current staffing position alongside the mitigation in place to ensure staffing levels are safe and sustainable.

The report summarises the review performed for nursing and midwifery from November 2020 to June 2021 and offers any recommendations as a result.

2. Background and Context

Demonstrating safe staffing is essential for all healthcare providers in order to comply with CQC regulation, NMC recommendations, NICE guidance, BAPM, RCPCH, RCN, RCM and Birthrate Plus (BR+).

It is acknowledged that ensuring appropriate staffing levels on wards in line with the above recommendations has many benefits including improved recruitment and retention, reduction in staff sickness levels, improved patient outcomes including mortality, high standards of care and a positive patient experience.

As a result of the ongoing Covid-19 pandemic, the Trust has continued to manage a constantly changing workforce situation to ensure patient and staff safety.

3. Current Position

The table below provides an update for the reporting period of the UNIFY fill rate data and the Care Hours per Patient Day (CHPPD) that is collected. It shows a percentage of the Planned v Actual staffing levels for both the day and night shifts split by registered and unregistered.

Month (20/21)	Realtime Staffing (standard >90%)	CHPPD (standard >7)
June 21	90.4%	9.5
May 21	88.6%	8.9
April 21	92.8%	9
March 21	90.0%	9.5
Feb 21	92.9%	9.2
Jan 21	86.0%	9
Dec 20	89.6%	9.4
Nov 20	90.7%	9.5
Average	90.1%	9.25

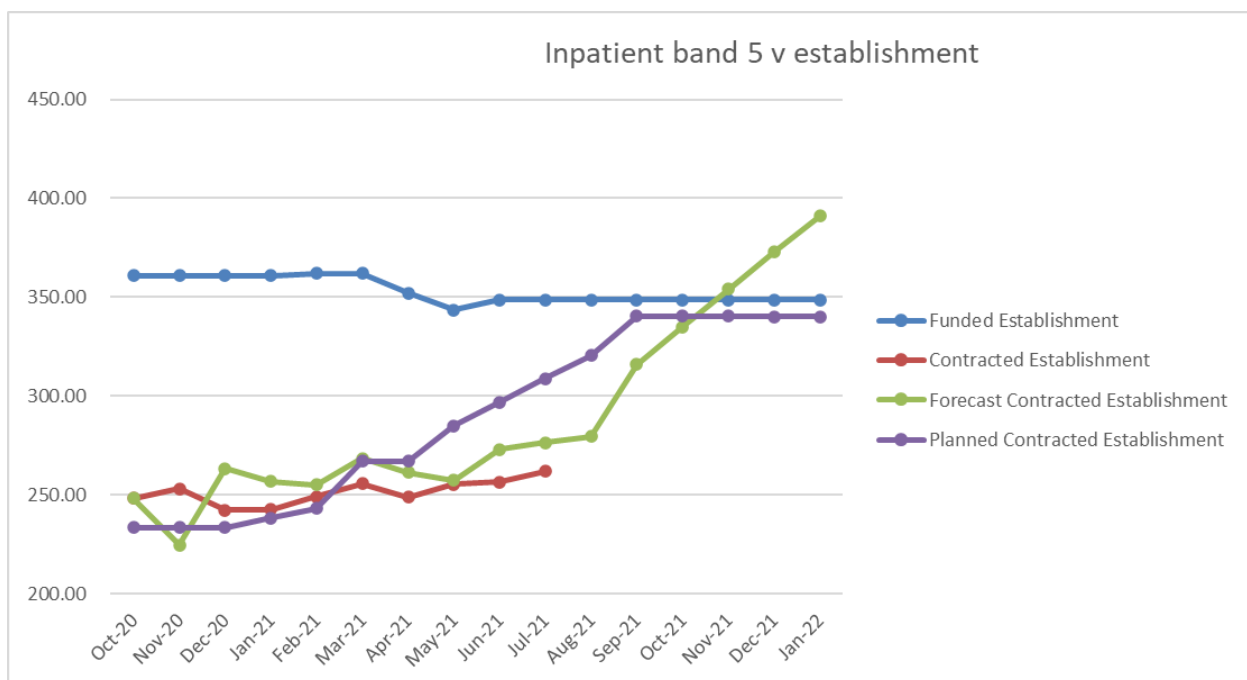
External reporting of UNIFY data continues monthly recognising during this reporting period. The Trust continued to report figures that were multifaceted due to the re-deployment of staff to frontline services and Covid-19 re-deployment. Staff shielding is reflective of the impact on safe staffing reporting within this review period however the Trust continued with monthly reporting to the Workforce Committee to maintain a level of oversight and transparency.

We have continued to work on reviewing all the inpatient demand templates to ensure accuracy of reporting reflective of bed base numbers, patient acuity and staff to patient ratios. New and emerging roles (such as Assistant Practitioners (AP's), Nursing Associates (NA's), Advanced Nurse Practitioners (ANP/ACP's) etc align to the review.

Against the national standards expected, the Trust has on average delivered for unregistered staff groups on day shifts and registered on night shifts. Areas below target have been supported by deployment of supporting workforce.

There has been further progress in recruiting to vacancies. The Trust band 5 RN vacancy for inpatient areas is 92 (WTE). This is an improved position on 107 (WTE) reported in November 2020.

It is worth noting that the overall nurse band 5 number decreased slightly between November 2020 and June 2021 as a result of nurse establishment reviews, the outcome of appropriate skill mix reviews to offer adequate clinical leadership in medicine and to support patient pathways and flow in the adult bed base.



The forecast for the future is positive at this stage which will give the organisation the opportunity to further review safe staffing in conjunction with spend, activity, acuity, pandemic guidance and sickness rates. The graph above illustrates both the funded and contracted establishments and are based on assumptions for the turnover rate, student recruitment, retirees and international recruitment commencing. The forecasted establishment is updated on a monthly basis and is dependent on the best intelligence available. This will be closely monitored.

The impact of the international recruitment campaign will be seen within the months ahead of recruitment as the nurses join the NMC register. This will take our trajectory for fill against band 5 vacancies into 2022. The Trust has currently welcomed 70 international recruits at the end of June 2021. 52 of these nurses are not currently in receipt of their NMC registration and therefore not

practicing as a band 5 nurse within establishments. Of the 52 nurses, 29 have completed their Objective Structured Clinical Examination (OSCE) and are awaiting their PIN for NMC registration.

The HCA band 2 and 3 inpatient vacancy has been actively recruited to with no vacancies reported in June 2021. This has been as a result of a focused recruitment to vacancies and appointment of international nurses into band 3 posts whilst awaiting NMC registrations. The future vacancy position as the international recruits' transition into RN vacancies will be monitored and actively recruited with the inclusion of the trust Care Support Worker Development (CSWD) programme in collaboration with NHS Professionals.

The Accident and Emergency establishment review, based on the latest guidance, has identified requirement for investment when analysed against Covid-19 guidance and up-to-date safe staffing tools. Escalation areas have also been reviewed in the adult bed base in Q1 due to ongoing pressures, a deterioration in patient experience, increased movement of staff and staff unavailability. This will be taken through a separate proposal within the organisation and has been submitted as a statement of case.

The AHP Clinical Lead is focused on addressing the vacancy factor. Ongoing recruitment remains active across all grades with recent recruitment activity planned to reduce vacancy by 15 WTE during July/August 2021 with keen interest and additional interviews in place for the remaining vacancies. We continue to engage with local HEIs to support a learning environment for students and those commencing further learning.

Key activity continues to support students in the workplace across all professions, with a focus on reviewing our model of student to educator ratio in line with the Cheshire & Mersey AHP Network Clinical Placement Expansion Programme (CPEP). This will help increase the number of students and strengthen the pipeline into newly qualified therapy posts. Therapy leads also continue to support staff through the apprenticeship route of training.

4. Recruitment and Retention

Our recruitment strategy continues to evolve at pace, with a significant amount of proactive work ongoing, including strengthening our engagement with external partners, including local Higher Education Institutions (HEI), Health Education England (HEE), other local Trusts and NHSP Project to increase placement capacity for pre-registration nursing and midwifery student numbers by 50% to support the increase in student places with our HEI stakeholders.

By June 2021 the Practice Education Facilitator (PEF) team and the organisation has successfully increased our capacity by 91 and a total of 256 placements.

Key activities have been aligned to the Trust securing funding through the clinical placement expansion programme within Pan Cheshire and Mersey. Through the Clinical Placement expansion programme we have:

- Reviewed the number of supervisors and assessors in all clinical areas
- To review compliance with educator training to support capacity increase
- Agreed student capacity increase number with Higher Education Institutes

- Increase frequency of educator training
- Reinstate student forums to welcome feedback and inform future development of placement capacity increase
- Identified additional learning environments/ unutilised capacity within the organisation
- Reinstate Supporting Learners in Practice (SLIP) training

Following our successful launch of three new apprentice training options - Trainee Nursing Associate, Nursing BSc Apprentice and Nursing MSc Apprenticeship – we have recruited our second cohorts of both the Trainee Nurse Associates and Nursing BSc Apprentices helping to secure a strong pipeline for the future.

Improving the Healthcare Assistant (HCA) supply through re-engaging with Southport College to reintroduce the ACORN programme. This is a level 3 Health and Social Care Extended Diploma which supports progression to health and social care related degrees. The Care Support Worker Development programme recommenced with NHSP and scope engagement opportunities with the NHS Cadet scheme (on hold during pandemic).

International Nurse (IR) Recruitment programme commenced in June 2020 and by June 2021 we have had 70 arrivals. Together with the remaining nurses in our pipeline and those we will be welcoming from the Pan Mersey Collaborative programme we will welcome a further 92 nurses, with the current plan to have 81 of them in post by the end of December 2021.

Pastoral support to International Nurses has been high priority with regular ‘check in’ events and focused events with Boo Coaching. These have proven to be positive for the new nurses joining our teams and further events planned to support ongoing professional and personal support is required. The Trust has reviewed its INR ‘onboarding’ booklet as part of the welcome to the Trust processes.

The Preceptorship programme has undergone review reflective and aligned to the Cheshire and Mersey preceptorship offer. All INR have now commenced the Trust preceptorship programme supporting their ongoing career development and aspirations.

Agency migration to bank and continued focus on block booking of flexible workers has been implemented to maintain continuity of care.

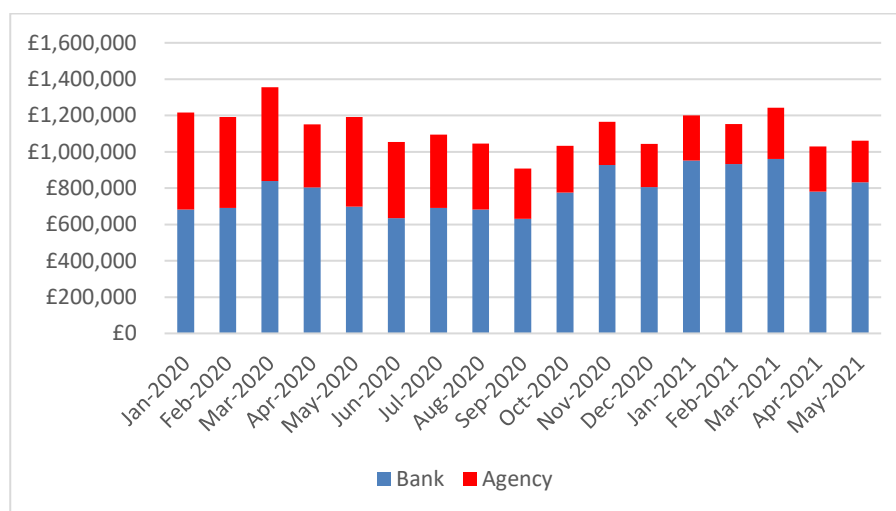
Following our work to recruit to all our HCA vacancies we were successful in receiving £51,000 from NHSE/I which will be utilised to provide further support in the delivery of the healthcare certificate.

5. Temporary Staffing & NHS Professionals (NHSP)

When staffing numbers fall below agreed staffing levels within an area there are systems and processes in place that supports deployment across CBU's to mitigate immediate concerns. Managers have the tools to fill gaps with temporary staffing through the Trust's collaborative working with NHSP.

During the period November 2020 to February 2021, we ran the second NHSP bank incentive scheme, which offered a financial bonus to nurses working extra shifts via the bank. This was necessary due to the number of clinical staff absent either due to shielding or sickness combined with the high level of vacancies. We had also found that agency supply had become increasingly challenging hence looked for different solutions. The incentive provided a useful boost to the numbers of staff taking up shifts and helped us to provide safe staffing levels and is something we will continue into the next incentive across the summer months reflective of the ongoing pandemic and impact on nurse staffing. We are supportive of this scheme in the future.

The graph below demonstrates fill against spend over the last twelve months. Overall spend has shown variable movement in run rate, agency spend has been significantly reduced which offers much more assurance from a governance perspective and use of the incentive scheme allows this to continue.



6. Additional Roles – ‘Growing our Own’

The Trust continues to use the apprenticeship offering to develop existing staff, utilising both the Nursing Associate and Assistant Practitioner standards. Nursing associates work as a vital part of the wider nursing team with the role sitting between health and care assistants and registered nurses. Recent recruitment has attracted external candidates from a diverse section of the NHS workforce. Assistant practitioners continue to bring skills and experience in a particular area of clinical practice, with our existing trainees working within Therapies and Endoscopy. We continue to work with existing staff to promote the role and to ensure staff meet the entry requirements for both programmes, in particular accredited maths and English qualifications.

The Trust has proactively recruited to Trainee Nursing Associates and Trainee Assistant Practitioner programmes in partnership with local HEIs. As a result, we have the following practitioners which are qualified, in training and vacant band 4 positions within our workforce.

The Trust welcomed its second cohort of Registered Nurse Apprentices in March 2021, attracting both existing and external staff to the position. A registered nurse degree apprenticeship (RNDA) allows staff to train in a range of practice placements whilst attending university. Most RNDAs take four years, but for existing nursing associate or assistant practitioners the duration could be reduced

to two years as previous learning and experience is recognised. The Trust is working with HEE with the RNDA Project as part of the Government's manifesto commitment to increase the number of Registered Nurses and as a result is supporting the following apprentices, seeing the first RNDA's qualify in August and September 2022. Future cohorts are in discussion.

Further to this we are:

- Improving the Healthcare Assistant (HCA) supply through re-engaging with Southport College to reintroduce the access to healthcare assistant programme (ACORN), recommenced the Care Support Worker Development programme with NHSP.
- IR programme commenced in June 2020 with international nurse arrivals continuing during 2020-2021 despite the pandemic.
- The Trust have aligned to nationally funded NHSE/I band 2 HCA recruitment campaign and achieved near zero vacancies to date.

Advanced Nurse Practitioners (ANP)/Advanced Clinical Practitioners (ACP)

There are currently a total of 43 trained and trainee Advanced Clinical Practitioner posts within the Trust across the three Corporate Business Units including 16 Allied Health Professionals practising within physiotherapy, two consultant nurses working in ACU and three Frailty Practitioners.

The CBUs' and specialities are currently developing plans and in June obtained funding for a further three ACP posts (Musculoskeletal interface service, Neonatal and ambulatory paediatric service and regional spinal injuries unit) and nine multi-professional advanced clinical practitioner modules.

7. Staffing Establishment Reviews & CBU Updates

Within Clinical Business Units (CBUs), the ward establishment reviews have been undertaken for the inpatient ward areas. The reviews were undertaken using evidence-based modelling using a range of tools and resources:

- Safer Nursing Care tool (SNCT)
- the Model Hospital reviews
- Care Hours Per Patient Per Day (CHPPD)
- professional judgement
- NICE guidance
- Birthrate Plus
- Royal College guidance
- BEST Emergency care tool
- 'Confirm and Challenge' desk top review process to provide constructive clinical challenge
- acuity data including enhanced care requirements individual to each specialty
- local staffing profiles are discussed as well as education predictions to plan resources appropriately.

The skill mix undertaken has been implemented for all areas except for Theatres and Outpatient Teams. These alongside a review of escalation areas are currently progressing to ensure that the models of care and establishments are safe and appropriate.

External funding has been sourced for the Midwifery and NNU gap however potential investment is required for other areas.

In Medicine and Emergency Care CBU, a Lead Nurse has commenced in post and the Matron leadership structure has been strengthened.

A programme of work to redesign frailty pathways focusing on admission avoidance and re-direction of patients for assessment from the ED has been underway in partnership with the Acute Frailty Network (AFN). This is intended to deliver early comprehensive geriatric assessment and enable timely discussion about complex decision making in collaboration with the geriatric and medical colleagues, streaming patients to the area best suited to meet their needs. The team are enrolled on ACP training and funding and additional ACP posts to support the team are currently being advertised. The team have needed to be redeployed during the Covid-19 pandemic although this critical piece of work forms part of the CBU business plans and strategy and has recommenced with weekly meetings to progress at pace with the intention of testing the concept in Autumn of 2021.

The Planned Care CBU has undergone an organisational change initiative to enhance the surgical clinical pathway. A bed occupancy and acuity review has been completed as part of that organisational review and as a result Ward 11a (17 beds) has been closed and the staff and resources have been redeployed across the CBU. The Ward 11a resource has been allocated to Ward 10b to fund the unfunded six beds and the additional staffing required to staff those beds. In addition, resource has been directed to Ward G at Ormskirk to fund the extended bed capacity to 23 beds (seven beds). Resource has also been directed to fund the newly opened Post-operative Care Unit in the vacated four beds housed in Critical Care. Throughout the process no additional funding has been required, no staff have lost their substantive positions and vacancies have been funded from the re-allocation of resource. As a result of the moves, any resulting vacancies not filled by the Ward 11a moves have then gone out to formal recruitment to support the enhanced surgical pathways.

The Paediatric Unit does not currently always have supernumerary shift leaders due to the flow of activity and acuity, however there is a coordinator identified and staffing is flexed to support. Ward Managers are supernumerary three to five days per week to provide leadership and operational management of their areas. A further review is planned to check the ratios against activity / acuity in preparation for the next staffing review.

Neonatal staffing is measured against the British Association of Perinatal Medicine (BAPM) standards. Within the establishment review there was a deficit identified of five WTE nurses. The neonatal clinical network has also undertaken a review of neonatology staffing across the region in March 2021 and it has been confirmed that the gap will be funded.

The standard to provide 1:1 care in labour has been met for every woman during the reporting period.

The Delivery Suite Shift Coordinator is supernumerary to enable maternity to fulfil their role. The Shift Coordinator was rostered as supernumerary 100% of the time.

In the maternity department, a Birthrate Plus assessment (BR+) was last completed in February 2019. BR+ is a framework for workforce planning based upon an understanding of the total midwifery time required to care for women and includes a minimum standard of providing one-to-one midwifery care throughout established labour.

In response to concerns raised via the Ockenden Inquiry and midwifery staffing levels in Maternity Units across the country, Cheshire & Mersey region are funding Birthrate Plus assessments for all maternity units. Initial discussions have been had with the Birthrate Plus team and data has been submitted. We await a response.

Maternity Services implemented the Birthrate Intrapartum Acuity tool in 2020. Data is inputted into the system every 4 hours by the Delivery Suite Coordinator on the Delivery Suite and Shift lead on the Maternity Ward which measures the acuity and number Midwives on shift to determine the acuity score. Escalation adequately supports the movement of staff around the unit during periods of high acuity.

In 2019, the Sapphire Team was implemented to provide Continuity of Carer (CoC) for those women choosing to have their babies at S&O but who live outside the area. Maternity is currently reporting between 9-12% with the nationally set trajectory of 35% for March 2022 with a progression to CoC being the default model of care offered to all women by March 2023.

The Trust vision is to fully implement CoC as directed by the Better Births ambition. We have invited scrutiny from the Chief Midwife for NHS England and the National Lead of Continuity to assess the workforce model developed by the Maternity team. This has evidenced midwifery shortfalls. This along with our vision to do a 'full bang' approach to quickly achieve 100% compliance with our women on the Continuity of Carer pathway has resulted in delays in meeting trajectories of 35% by March 2021.

The current model of midwifery care is a more traditional model of maternity care and so we have commenced staff engagement sessions and the Senior Maternity team have commenced meetings with HR and staff side union representatives with a plan to undergo an organisational change which has not been previously possible due to restrictions advised by NHS Employees during the Covid-19 pandemic. It is expected that the timescales for this will be four months to fully implement. A Quality Improvement (QI) event is planned for September 2021 with the regional Chief Midwife to develop a refreshed plan.

We are pleased to share that the Maternity team have been successful in bidding for five additional midwives to support the recruitment of additional midwives to put us in a positive position to meet these timescales for implementation. International recruitment of midwives is also being explored.

Senior Midwifery oversight until 8pm and at weekends has been introduced to support staff by having an 'helicopter view'. This enables efficient response to any staffing shortfalls, unpredicted demands on the service and any other concerns that may arise.

Daily oversight is in place to monitor staffing levels and risk across the two sites by a Matron. Staff may be required to move due to gaps.

Sickness absence continues to be an issue in most clinical teams. The team is being supported by HR to undertake 'deep dives' into reasons for absence so that focused support can be provided. Staff are being supported via the sickness absence policy and trends and themes are reviewed at monthly CBU Governance meetings.

Senior leadership visibility has increased to support staff in addition to Director of Nursing, Midwifery and AHP 'Quality and Safety Walkabouts' each week in all clinical areas.

Any patient safety incidents are cross referenced against staffing levels and these are discussed at weekly patient safety meetings.

In all CBUs, each month the planned versus actual staffing levels are submitted and monitored through the Allocate rostering system. These are reviewed at roster check and challenge meetings by the Director of Nursing, Midwifery and AHPs. The meeting has recently been reviewed due to the progress made with rostering. Going forward there will be enhanced focus to enable further improvements in targeted areas.

All safe staffing measures are reviewed monthly at PIDA and Workforce Committee with an opportunity to escalate concerns.

8. Conclusion

Safe staffing levels impact on the ability of nursing, midwifery and AHP staff to provide high quality care and a positive patient experience. As with previous reports, the Trust continues to carry several band 5 RN vacancies although this is noted to be reducing with a positive forecast anticipated. Risk is mitigated with the use of temporary staffing and incentives.

The staffing is accurately reflected in the Trust Board Assurance Framework (BAF) and the Clinical Business Unit's Risk Registers.

Reviews of staffing numbers and skill mix will continue and reported monthly at PIDA and bi-annually at Trust Board. The Trust will continue to utilise national patient acuity tools with future establishment reviews and proposed changes will be based on triangulation of acuity, current quality indicators, outcomes and professional judgement.

9. Recommendation

The Committee is asked to receive the report, support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.

References

Care Quality Commission (2019) *Regulation 18: Staffing*, Available at: [Regulation 18: Staffing | Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications-and-reports/regulation-18-staffing) (Accessed: 15th July 2021).

National Institute for Health and Care Excellence (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals*, Available at: [Overview | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE](https://www.nice.org.uk/guidance/CG133) (Accessed: 15th July 2021).

National Institute for Health and Care Excellence (2015) *Safe midwifery staffing for maternity settings*, Available at: [Overview | Safe midwifery staffing for maternity settings | Guidance | NICE](https://www.nice.org.uk/guidance/CG133) (Accessed: 15th July 2021).

Nursing and Midwifery Council (2016) *NMC Briefing: Appropriate staffing in health and care settings*, Available at: [Safe staffing guidelines - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/standards/safeguarding/safe-staffing-guidelines) (Accessed: 15th July 2021).

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 OCTOBER 2021
Agenda Item	SO006/21	FOI Exempt	NO
Report Title	SAFEGUARDING ANNUAL REPORT 2020/21		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Sharon Seton, Assistant Director of Safeguarding		
Action Required	<input type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
<p>The Safeguarding Annual Report for 2020 / 20201 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 01 April 2020 – 31 March 2021. The purpose of the annual report is to inform the Southport and Ormskirk Strategy and Operations Committee of safeguarding activity, providing assurance to the Committee that the organisation has robust processes in place to safeguard those who use Trust services and to highlight areas of challenges in safeguarding provision.</p>			
Executive Summary			
<p>All NHS bodies have a statutory duty to ensure that they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2018); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).</p> <p>The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.</p> <p>The Trust safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the unborn, children, young people and adults who are at risk of abuse or neglect. The safeguarding team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adult's team based at Southport and the children team based at Ormskirk. The team work closely with both Sefton and Lancashire County Councils and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.</p> <p>This report demonstrates the work S&O NHS Trust has in continuing to fulfil its responsibilities to safeguard children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults, including the Mental Capacity Act (MCA) during 2020-2021. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs). These</p>			

Boards aim is to ensure agencies in Sefton and Lancashire are working together effectively to keep children, young people and adults safe. The aim of this report is to provide an overview of the key developments, progress, achievements and challenges for the Safeguarding Team.

Recommendations

The Committee is asked to recognise the achievements made by the Safeguarding Team this year outlined in the report and agree the suggested next steps for the year ahead.

Previously Considered By:

- | | |
|---|---|
| <input type="checkbox"/> Finance, Performance & Investment Committee
<input type="checkbox"/> Remuneration & Nominations Committee
<input type="checkbox"/> Charitable Funds Committee | <input type="checkbox"/> Quality & Safety Committee
<input checked="" type="checkbox"/> Workforce Committee
<input type="checkbox"/> 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:

Sharon Seton, Assistant Director of Safeguarding

Presented By:

Bridget Lees, Director of Nursing, Midwifery and Therapies

Safeguarding Team Annual Report 2020/21

Author: Sharon Seton

Assistant Director of Safeguarding



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1.0 EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2020 / 2021 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2020 – 31st March 2021. The purpose of the annual report is to inform the Southport and Ormskirk NHS (S&O) Trust Board of safeguarding activity, providing assurance to the Trust Board that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2 All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2018); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

1.3 The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

1.4 The Trust safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the un-born, children, young people and adults who are at risk of abuse or neglect.

1.5 The safeguarding team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adult's team based at Southport and the children team based at Ormskirk. The team work closely with both Sefton and Lancashire County Councils, and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.

1.6 Key roles of the team include:

- Providing support and an extensive safeguarding knowledge to all staff across the Trust.
- Providing daily operational responsibility for safeguarding concerns, recognising when a concern may require referral to external partners.
- Provide a Trust contact for the Local Authorities and all other external agencies, for the process of referrals and for the sharing of relevant information.
- Work with partner agencies to ensure the decisions and processes support the ways of working for an acute trust.
- Leading and ensuring a Trust-wide culture that supports staff in identifying and raising safeguarding concerns.
- Participate with Local Safeguarding Board processes to learn lessons from cases where the un-born, children or adults die, or are seriously harmed as a result of abuse.
- Ensuring engagement with Local Safeguarding Boards and any local arrangements for safeguarding both adults and children.

- Ensuring Trust staff access training that is compliant to the intercollegiate documents for safeguarding adults and children; monitoring and improving compliance and escalating as appropriate.
- Ensure the Trust works and is compliant with legislation and statutory responsibilities

1.7 This report demonstrates the work Southport and Ormskirk NHS Trust has in continuing to fulfil its responsibilities to safeguard the un-born, children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs).

1.8 From the quarterly submission of key performance indicators (KPIs), to South Sefton Clinical Commissioning Group (CCG), the Trust achieves a RAG rating of GREEN in the relation to Local Authority children and adult referrals, mental capacity act and deprivation of liberty safeguards (DoLS).

1.9 Case scenarios at the end of the report will provide examples of the impact of safeguarding on patient experience, the complexities of cases the safeguarding team become involved in, and the diverse nature of safeguarding work. They will demonstrate how important it is that the Trust staff are professionally curious to understand the reason for attendance at the Trust, and the importance of wider assessment to understand the risks.

2.0 INTRODUCTION

2.1 The team structure is set out in Appendix 1.

2.2 The safeguarding team has continued its journey of improving safeguarding arrangements within the Trust throughout 2020/21. The team continue to strive for continuous and sustained improvement, in particular in relation to the safeguarding policies being in place, training compliance, and responding proportionality and in a timely manner to safeguarding concerns.

2.3 Key Achievements in 2020-2021

- Completion of all actions for Southport and Ormskirk from the Joint Targeted Multi-agency Inspection (JTAI) for children's mental health services in Sefton
- Development of an MCA and DoLS Portal
- Development of an adult e-referral form via order comms'
- Established regular meetings with MerseyCare in regard to them providing a Mental Health Act Administration Service.
- Introduction of a safeguarding children's practitioner in to the safeguarding adult team
- Health Sexual Violence Liaison Officer qualified as an Independent Sexual Health Advisor
- Development of a Standard Operating Procedure (SOP) for 16-17 year olds in adult hospital setting

- Introduction of quality assurance process for all safeguarding referrals to children's social care referrals
- Development of a Memorandum of Understanding (MoU) with Sefton Local Authority in relation to safeguarding concerns raised against the Trust
- Revision and implementation of the safeguarding documentation in the accident and emergency pack and causality cared
- Development and delivery of Safeguarding Ambassadors Enhanced training
- Establishment of a task and finish group to review the implementation of risk reduction training
- Publication of the All Age Restrictive Practice Policy
- Publication of the Safeguarding Children's Policy
- Review and revision of the Female Genital Mutilation Policy
- Review and revision of the Mental Capacity and Deprivation of Liberty Policy
- Review and revision of the Counter Terrorism Policy
- Review and revision of the Learning Disability Policy
- Review and revision of the Allegations Against People in Positions of Trust Policy
- Participation in the Trust's CQC unannounced visit
- 26.5% increase in DoLS applications.
- 100% compliance in the MARAC process (multi-agency risk assessment conference).

2.4 The team has utilised several methods to communicate and raise awareness across the Trust this includes:

Safeguarding children's link nurse	Monthly link nurse meeting undertaken
Safeguarding ambassadors	Launched January 2020 across the Trust to support sharing information and disseminate training/lessons learned
Representation at the planned and unplanned governance meetings	Core agenda item at the monthly meeting
Included in Trust news	7 minute briefings / LSCB and LSAB newsletters / /safety notices / safeguarding ambassadors / links to LSABs
Safeguarding Briefs	In relation to changes in process and or practise

3.0 GOVERNANCE ARRANGEMENTS

3.1 The Trust has a Safeguarding Assurance Group (SAG). The meeting is attended by representatives from the Local Authority, and Designated Nurses from South Sefton and Lancashire CCG's. The meeting has regular representation from the Associate Directors of Nursing. The meetings have been chaired by the Director of Nursing, Midwifery, Allied Health Professionals, Governance and Risk. An advice, alert, assure (AAA) report from the meeting is submitted to the Trust Safety and Quality Committee.

3.2 A quartile KPI report is submitted to South Sefton CCG, after which the CCG provide an assurance report for the Trust. The Assistant Director of Safeguarding undertakes business meetings with the Designated Nurse and Designated Practitioner for South Sefton CCG.

The meeting occurs prior to the SAG meeting and the purpose is to review the KPI return for the previous quarter. The KPI return feedback is an agenda item at the Trust Contract & Clinical Quality Review Meeting (CCQRM), which the Assistant Director of Safeguarding attends when requested.

3.3 The children's safeguarding team has a monthly children's steering group meeting with attendance from the relevant Clinical Business Units. The Named Nurse adult has regular representation at the governance meetings for planned and emergency care, and provides a safeguarding report for each of these meetings.

3.4 The Trust's safeguarding policies are currently all in date, and a number of the policies have been reviewed and updated this year. Policies are approved by the Safeguarding Assurance Group; governance meeting for planned and emergency care; department meeting in specialist services; as required by workforce committee, before finally being presented through the Trust policy ratification group.

4.0 ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Director of Safeguarding provides Trust representation at the Sefton LSCB, and the Safeguarding System Leaders Business meeting for Lancashire, which sits under the Safeguarding Health Executive Group. In Sefton, the LSAB does not have provider representation, although the Assistant Director of Safeguarding provides membership at the Lancashire LSAB. Membership at the Boards ensures that the Trust is sighted on all aspects of the safeguarding agenda, and attending the Board allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards.

4.2 The Named Nurses and practitioners represent the Trust at both Lancashire and Sefton LSAB and LSCB/CSAP sub-groups, and other working groups, however, it is acknowledged that during this year many of the groups were temporarily suspended.

There is representation by a member of the adults safeguarding team at:

- Pan Mersey LSAB Policy, Procedure and Practice Sub Group
- Pan Mersey LSAB Workforce Development Sub Group
- Pan Mersey LSAB Performance Sub Group
- Pan Mersey LSAB Quality Assurance Sub Group
- Sefton & Liverpool Health Providers Group
- Lancashire LSAB MCA Sub Group
- Lancashire LSAB MCA Best Practice Sub Group
- Lancashire LSAB Learning & Development Sub Group
- MARAC Sefton
- Lancashire Serious Adult Review (SAR) Group
- Sefton Channel Panel
- Sefton SEND Improvement Group
- Sefton Domestic Abuse Steering Group

There is representation by a member of the children's safeguarding team at:

- CE strategic sub group Sefton
- CE Health group Sefton
- Child death overview panel (CDOP) panel for both the LSCB/CSAP
- CSAP Health meeting
- CSAP Tactical meeting
- Early help sub group Sefton
- LSCB training pool
- LSCB Learning & Development sub group Sefton
- Health Forum Sefton
- ICON Sefton and Lancashire
- MACE LSCB Subgroup Sefton
- Multi Agency Audit group Lancashire and Sefton
- MARAC Lancashire
- Pre-birth meeting
- Policy and Procedure sub group
- Sefton Looked after Children Collaborative
- Social Care Review meeting Sefton and Lancashire
- Lancashire Activity call
- Substance misuse working party Lancashire

4.3 The Assistant Director of Safeguarding provides representation at the Merseyside Safeguarding Providers Clinical Network meeting. This is a Merseyside group of health providers who meet bi-monthly to align local practice and share lessons learnt and developments. The group has representation from the CCG Designated Professionals across Merseyside. Unfortunately during 2020/21 the group suspended the meetings due to other pressures during the pandemic.

4.4 Attendance at these groups allows the Trust to have up-to-date knowledge and informs areas for focus within the team's strategic agenda. Membership allows the team to be part of the development of safeguarding across Sefton and Lancashire, and ensures that Trust processes are in line with partner agencies. Through these subgroups, the team has been involved in the development of policies, audits, tools and training to meet the standards required by the LSAB's and LSCB/CSAP.

4.5 One of the children's Specialist Practitioners is a member of the Sefton 'Training Pool' supporting and delivering safeguarding training across the network. This year training has focused on: the voice of the child; Working Together; child exploitation; on-line safety, familial sexual abuse; fabricated induced illness.

4.6 The Named Midwife is a member of the National Maternity Safeguarding Network and attends MS teams meetings monthly. The named Midwife has contributed via a task a finish group to a review of the pre-birth assessment in Lancashire, which will be published on the Lancashire CSAP website. The Named Midwife is a member of CDOP for both Lancashire

and Sefton and is represented on both CDOP panels. The Named Midwife has been a member of the ICON task and finish group in Sefton, and represents the Trust a task and finish group in Lancashire, which is aiming to stream communication pathways between midwifery and drug agencies. The Named Midwife is a member of Early Help Partnership for Sefton. The Named Midwife attends monthly meetings with Sefton & Lancashire Children's Social Care Managers, in order to discuss and review referrals and open cases in relation to the un-born.

4.7 The Named Nurse children attends the covid working group which was established in the this year, and has representation from the Designated Professionals for Lancashire CCG, Community Care Services, Social Care and other providers

4.8 The safeguarding team provide 100% representation at all requested strategy meetings, child protection conferences and core group meetings. Reports for these meeting may be provided verbally, written or via email, as requested. The safeguarding team support the SAR/CSPR process by providing requested chronologies; providing panel membership; ensuring participation at practitioner events. The safeguarding team provide representation at local MACE, CDOP and MARAC meetings. Prior to the meetings the team complete all requests for information within the given time-frame, and subsequent actions from these meetings are completed. The safeguarding team will support clinical staff to complete court reports, and the team ensure all reports are quality assured prior to submission.

4.9 In order to recognise any safeguarding concerns the adult team attend the monthly 'regular attenders' meeting at Southport's AED, which includes representation from community Matrons; NWAS; community drug and alcohol service; mental health Liaison team (MHLT); local authority. When required the Named Nurses will organise and host multi-professional and multi-agency meetings, in order to share concerns and discuss specific cases and agree a plan of care.

5.0 TRAINING COMPLIANCE

5.1 Compliance in children's safeguarding training has demonstrated achieving compliance in level 1, although during this year this has not been achieved for level 2 or level 3. This is further evident in the adults level 2, MCA and PREVENT wrap training. Compliance has been achieved in adult level 2 and level 3 and PREVENT awareness training. Level 3 children's training (usually face to face), has been provided to the relevant staff as a PowerPoint with additional notes. Once completed staff sign a completed form and return to the safeguarding team, who will notify training to update the individual's training record.

5.2 The training report shows compliance for Level 3 safeguarding adult training has decreased to 43% at the end of Q2. This is the result of realigning the training required by this group of staff following the publication of the adult roles and competencies intercollegiate document. The Assistant Director of Safeguarding presented to the CCG that a smaller number of people required level 3, n=20, as opposed to the previous number of 80. The training database took some time to demonstrate the above changes, and therefore, once updated the data demonstrated compliance.

5.3 Executive Board training was delivered in March 2020, and with the addition of the annual report the Board members will be compliant for 3 years.

Table 1: Southport and Ormskirk NHS Trust Safeguarding Training Compliance

	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Safeguarding Adults L1	92%	90%	90%	84%	86.4%	89%	91.3%	90.6%
Safeguarding Adults L2	89%	88%	86%	86%	84%	87.1%	88.5%	88.1%
Safeguarding Adults L3	85%	85%	66%	58%	45.6%	43.5%	85.2%	91.3%
Safeguarding Children L1	94%	93%	91%	87%	87.8%	90.2%	93.4%	91.6%
Safeguarding Children L2	93%	92%	90%	87%	82.5%	86%	88.1%	85.9%
Safeguarding Children L3	84%	85%	86%	80%	76.4%	81.4%	88.4%	83.5%
MCA	87%	88%	83%	76%	76.1%	78.2%	79.6%	79.9%
Prevent Awareness	97%	97%	97%	95%	80.1%	88.3%	91.9%	92.8%
Prevent WRAP	89%	90%	90%	88%	85.2%	86.6%	87.9%	86.4%
Level 4 Training	100%	100%	100%	100%	100%	100%	100%	100%
Executive /Board Training	100%	100%	100%	With the presentation of a yearly annual report compliance will be maintained for 3 years				

5.4 Each month the Clinical Business Units (CBU's) receive the Trust training report and can monitor their compliance levels. The Associate Directors Nursing are required to present a recovery report to the Safeguarding Assurance Group, should their compliance be below 90% in any one or more levels.

5.5 E-learning is provided for Level 1 and Level 2 safeguarding adults; Level 1 and Level 2 safeguarding children; Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards PREVENT Level 3 -5. In 2019 the single MCA training tier was replaced with 2 tier MCA training programme and the Trust training report now reflects this change.

5.6 With the suspension of face to face training in the past year level 3 children's training has been provided to the relevant staff as a PowerPoint with additional notes. Once completed staff sign a completed form and return to the safeguarding team, who will notify training to update the individual's training record. For Trust induction information handouts were developed and are provided to all new staff, with the expectation that their relevant level of safeguarding training is completed within 6 weeks, of commencing at the Trust.

5.7 The Adult Safeguarding team have supported the Older Peoples training throughout 2020/2021 providing a face to face session in regard to MCA, and sharing real cases studies in order to facilitate the sharing of lessons learned.

5.8 The Named Nurse Adult has facilitated the safeguarding ambassador's role for approximately 60 staff across the Trust. It is the ambition of the team to have in all clinical areas at least one ambassador, who will receive additional awareness training in a range of subjects, in order that they are equipped to support the safeguarding agenda in their work area. Topics to date has included: mental capacity and DoLS; self-neglect; domestic and sexual abuse; children's safeguarding.

5.9 Safeguarding children's training is reviewed yearly and the themes this year have included: Social Care and early help referrals; criminal exploitation and assaults; mental health and suicide in young people; voice of the child; young carers; children with ADHD; Looked After Children; domestic abuse; adverse childhood experiences (ACEs).

5.9 The safeguarding team attend an array of multi-agency training in order to maintain their compliance to level 4 training.

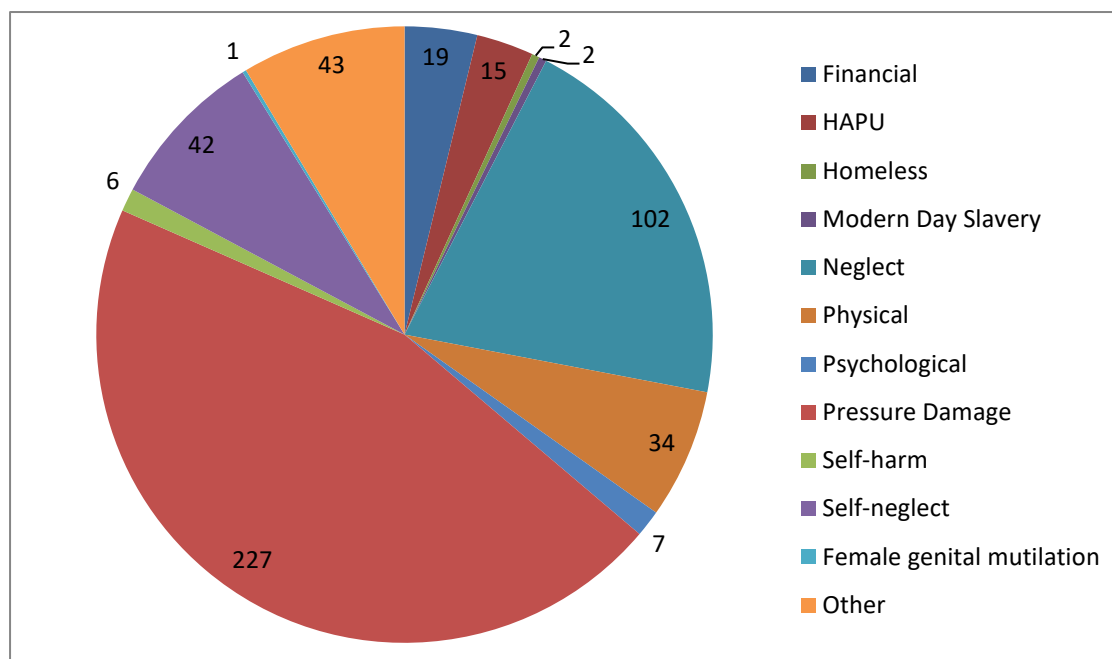
6.0 SAFEGUARDING ACTIVITY

6.1 Adults

6.2 The adult's team collates data regarding safeguarding referrals and safeguarding concerns raised within the Trust. The data is extrapolated from completed datix's and allows the team to identify areas of concern.

6.3 In 2020/2021 there have been 862 datix safeguarding concerns (Table 2), including 172 for domestic abuse and 190 for sexual abuse, this is an increase of 25.83% compared to 2019/2020. In addition, there has been 1433 applications for a DoLS authorisation, and this reflects a 26.5% increase compared to 2019/2020.

Table 2: Adult Safeguarding Concerns as reported via Datix (excluding DoLS, Domestic Abuse and Sexual Abuse)



6.4 Data shows that 140 out of 500 concerns raised (excluding domestic abuse and sexual abuse) required a referral to a Local Authority (LA). It is worth noting that not all referrals to the LA would have progressed to a safeguarding inquiry, under S42 of the Care Act, 2014. The graph demonstrates this year has seen a 50% increase in self-neglect. While this would support the work of the LSAB's were self-neglect remains a key priority, on further review of the cases, it can be reported that most of the cases did not meet the criteria to be considered as self-neglect and requiring further intervention from partner agencies. The other themes demonstrated in the table have remained consistent with those of 2019/2020.

6.5 For adult safeguarding referrals, other than in an emergency when the LA 'duty team' will be contacted, staff complete an internal referral form which is then attached to the datix. All

safeguarding concerns will be quality assured and checked by the safeguarding team prior to submission to the LA; again this excludes emergency safeguarding concerns out of hours. This year the team has collaborated with colleagues in IT to design an e-referral form, with the intention to trial this as an alternative to the current paper-based process.

6.6 The adult team oversees 2 work-streams in terms of safeguarding referrals. The first relates to safeguarding alerts made by frontline staff. These are captured through the datix system, as staff are requested to complete an incident report when they identify a safeguarding concern. The second relates to safeguarding concerns raised against the Trust. These are investigated by the Local Authority under Section 42 of The Care Act 2014. This requires the Trust to complete an internal investigation and address the lessons learnt as a result of the investigation, by developing an action plan to support recommendations.

6.7 All safeguarding alerts against the Trust are sent from the Local Authority Safeguarding Team to the Trust’s adult safeguarding team, who oversee the investigation and liaise with the Local Authority regarding the outcomes. In 2020/21 there have been 31 S42 concerns raised against the Trust, this is an increase of 63% (n=12) from the previous year. The concerns were raised against planned care and urgent care across a number wards (Table 3).

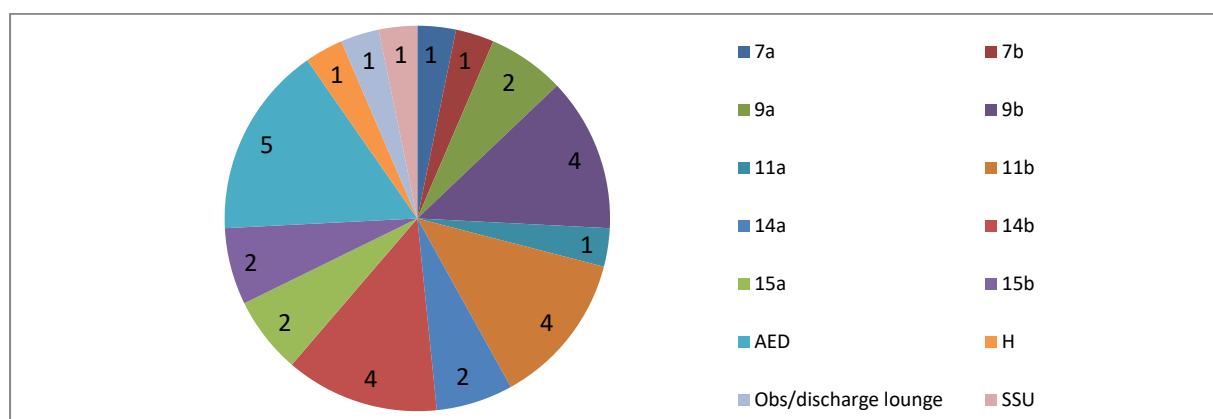
6.8 This year has seen the collaboration with Sefton LA to produce a ‘Memorandum of Understanding,’ recognising the responsibilities of each partner in the S42 process. This has been a significant piece of work with the LA, and acknowledges the partnership working between ourselves and the LA in regard to managing safeguarding concerns, and ensuring our patients are free from abuse.



Final SO MoU

6.9 The themes from the S42’s remain relatively consistent and are mostly in relation to concerns raised during the discharge process. The number of S42’s and the themes are monitored through Trust’s Discharge Improvement Programme. All concerns raised against the Trust enter the ‘harm-free’ care process, and are presented at the weekly ‘harm-free’ care meeting, in order to provide oversight of the investigation, learning and subsequent actions.

Table 3: Adult Safeguarding Concerns against the Trust (S42)



6.10 Making Safeguarding Personal

Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 36 individuals who had capacity to refuse intervention, and a referral was not made.

6.11 Children and Young People

In 2020/2021 the children's team had 1318 referrals and information sharing calls into Children's Social Care (CSC), (Table 4). The themes identified in the referrals are detailed in Table 5, and these remain consistent with last year's finding.

Table 4: Safeguarding Referrals and Information Sharing Calls to Children's Social Care

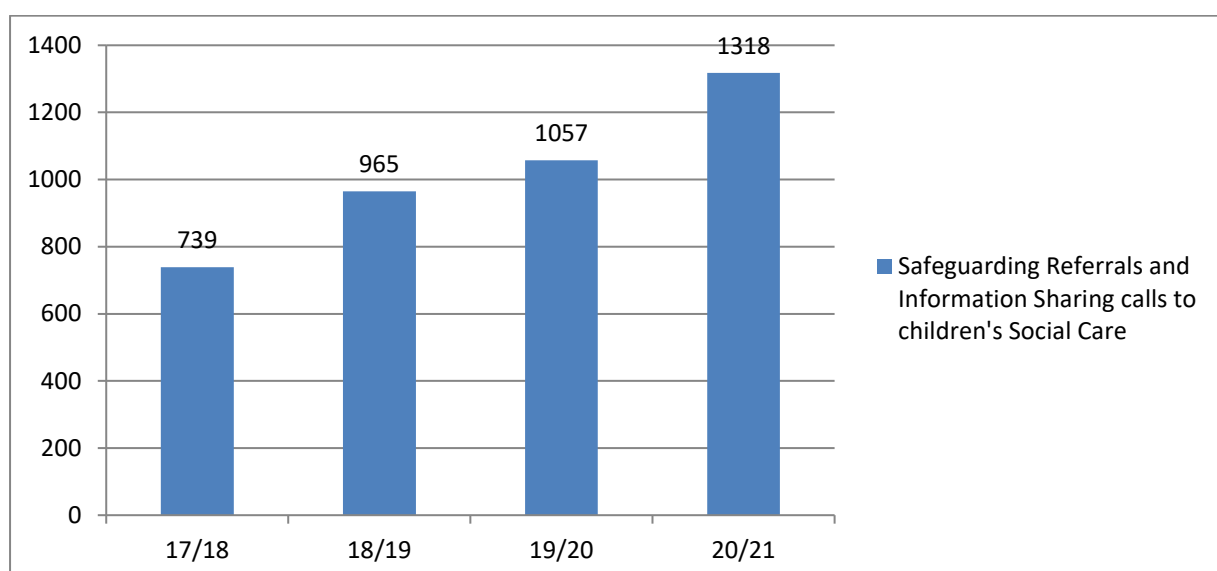
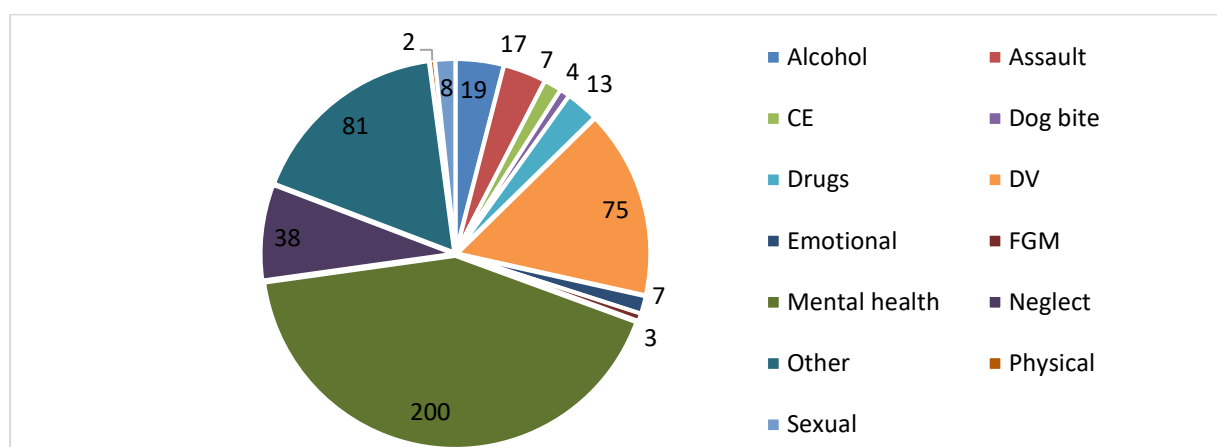


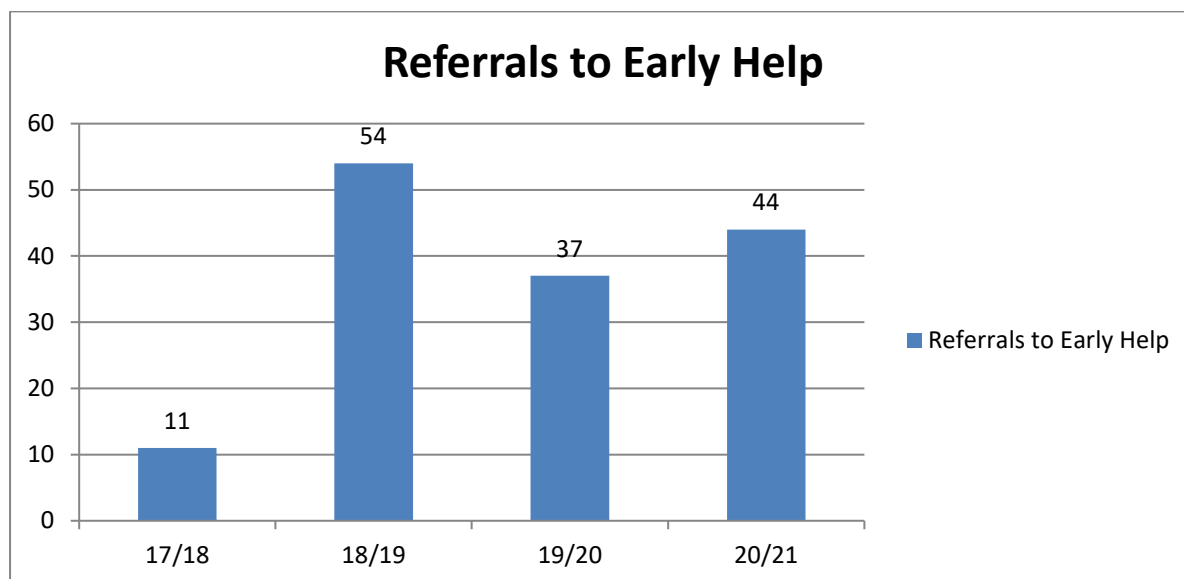
Table 5: Referral Theme by Primary Reason



6.12 This year has seen an increase in the number of referrals to Early Help services. The children's team review all referrals, and based on the often limited information that is

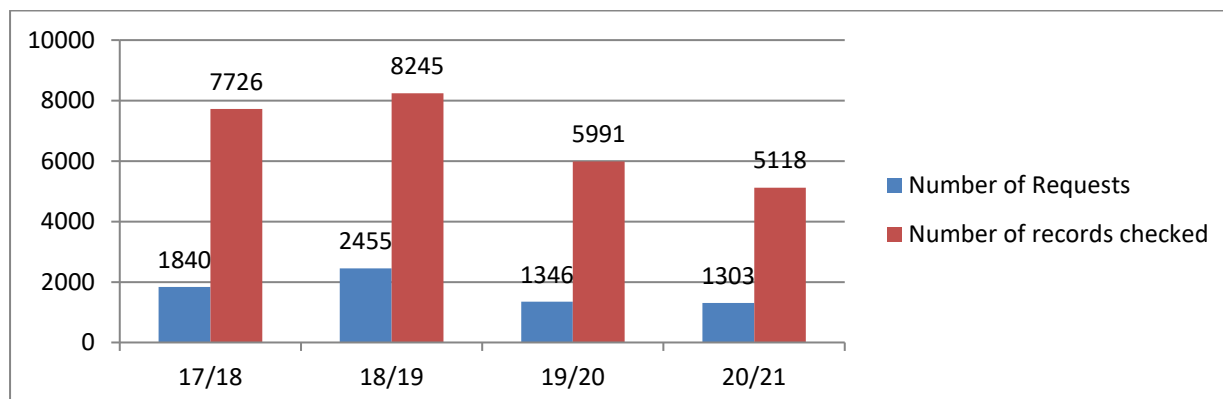
presented at the time the concern is raised, a decision is made as to whether the referral is to CSC or Early Help services.

Table 6: Number of Referrals to Early Help



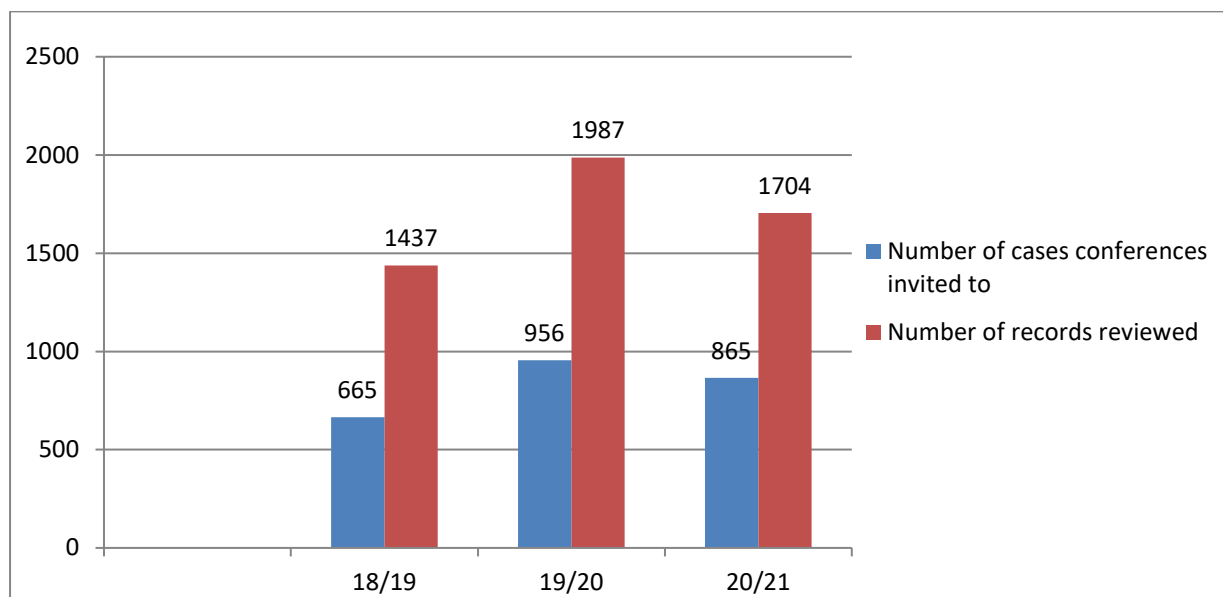
6.13 The children’s team is required to provide an extensive amount of safeguarding information to external agencies, (Table 7). In order to deliver this information in a timely manner, the team has a ‘duty 1’ and ‘duty 2,’ with one duty responding to internal operational concerns, and the other duty responding to external requests for information. The team has been commended for their responsive and timely return of this information. A single request for information can involve searching the clinical records of a number of patients, as the search can include a child, their siblings, their parents, grandparents and other members of the extended family. Recognising the impact of this, the MASH team had previously streamlined their process by only requesting information for relevant individuals, and by asking for information only dating back 2 years, (this is reflected in table 7). As an extra assurance the safeguarding practitioners will use their professional judgement, as to whether to disclose information dating back further than 2 years.

Table 7: Multi-agency Safeguarding Hub Requests for information



6.14 This year the children's team have received invites to 865 case conferences, (Table 8), resulting in 1704 clinical records being reviewed.

Table 8: Case Conference Invites and Requests for Information



7.0 CHILD DEATH OVERVIEW PANEL (CDOP)

7.1 The Named Midwife and Named Nurse children are CDOP Panel Members. During this year the Trust has received 39 child death notifications:

- 10 Sefton
- 28 Lancashire
- 1 other area

Of these children, 7 were known to the Trust. In accordance with the CDOP process, all requests for further information were returned within timeframe, whether the child was known or unknown.

8.0 DOMESTIC ABUSE and SEXUAL ABUSE

8.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and domestic abuse is recognised under The Care Act 2014 with its own category. This highlights the importance of identifying and acting on suspicions of domestic abuse.

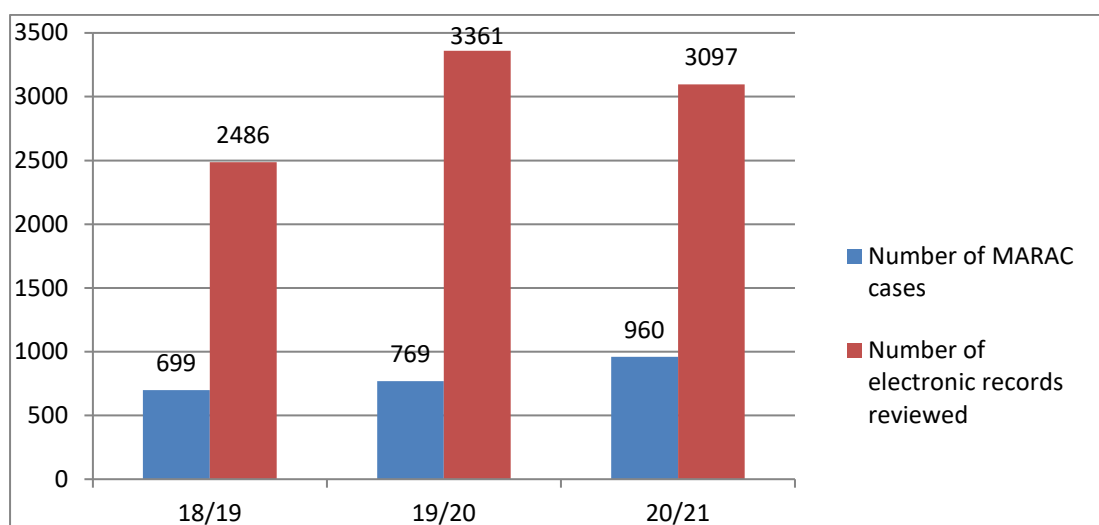
8.2 The Adult Specialist Practitioner remains the only health representative for the DA operational group for Sefton, which is responsible for providing the strategy for Sefton.

8.3 The Trust has sustained 100% attendance at the MARAC meetings this year in Lancashire and Sefton, of which there are 3 per month. The Trust further achieves 100% compliance with adding the relevant alerts to the patient's clinical records. There is a

process to remove the flag if in 12 months no further incidents in regard to the individual are referred to MARAC.

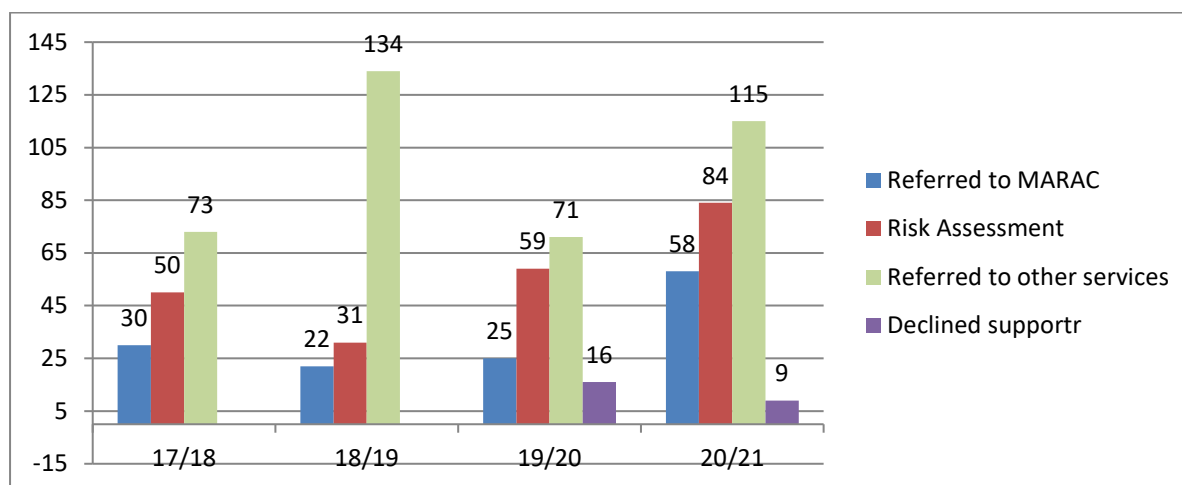
8.4 In 2020/21 there was 960 MARAC cases, representing a 24.83% increase compared to the previous year. This resulted in 3097 electronic patient records being reviewed, (Table 9) as each case requires the patient's and their significant others electronic patient record to be searched, in order that relevant and proportionate information is shared during the MARAC meeting. The Trust referred 58 cases to MARAC, which is a 132% increase compared to 2019/2020.

Table 9: MARAC requests for information



8.5 In incidents and or disclosure of actual or suspected domestic abuse, staff use the domestic abuse risk assessment to determine the most appropriate referral, (Table 10). The referral to MARAC is undertaken by the safeguarding team, following a review of the datix and the risk assessment, and after the engagement of the person disclosing the abuse.

Table 10: Risk assessments and referrals to MARAC



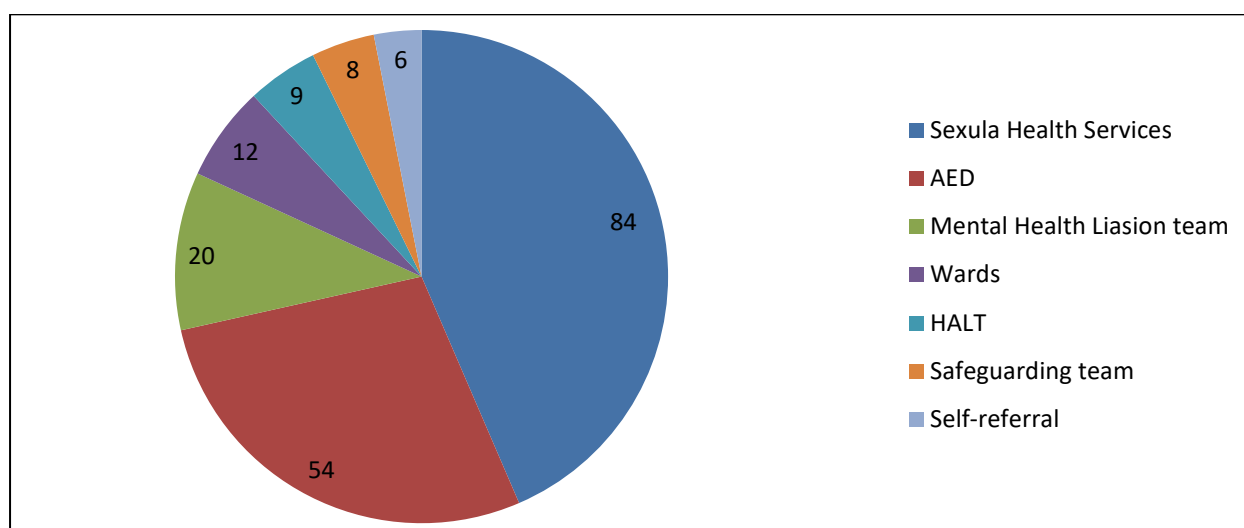
8.6 Health Independent Sexual Violence Adviser (ISVA)

The Office of the Police and Crime Commissioner, in conjunction with Lancashire Constabulary and Blackpool Teaching Hospitals, undertook a piece of work within Blackpool to map numbers of sexual offences reported to police, availability of support services, staff caseloads and links between them. Data obtained from Blackpool Teaching Hospitals based on a small dip-sample of 50 of Blackpool police's cases, threw up concerning data about the number of victims not in receipt of support, who have subsequently presented at AED in crisis, yet made no disclosure of any sexual offence to hospital staff.

8.7 The Office of The Police and Crime Commissioner Lancashire has in partnership with NHS England and Blackpool Teaching Hospital Trust, introduced Health Independent Sexual Violence Adviser's (ISVA), across Lancashire. Originally this was for a period of 2 years; however this period has now been extended for another 5 years, from March 2022.

8.8 The Health Independent Sexual Violence Adviser (ISVA) is based within the safeguarding team. The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 195 referrals made from a range of sources, (Table 11).

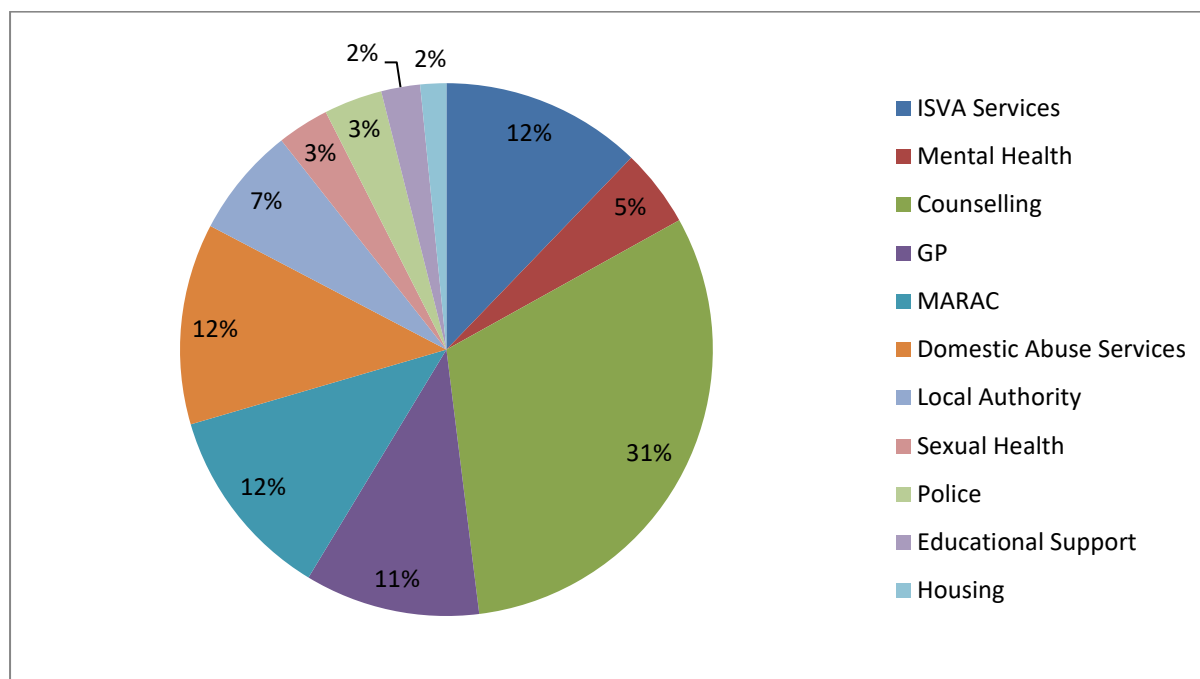
Table 11: HISVA Referral Source



8.9 The Percentage of patients not open to any Sexual Abuse Services prior to HISVA engagement was 82%, and the percentage of patients who had experienced recent sexual abuse (in last 6 months) was 29%, with 71% experiencing non-recent sexual abuse.

95% of patients, who were referred to the Health ISVA, did not readmit to AED in the following quarter with a complaint secondary to sexual abuse (for example mental health, substance misuse). It is likely that this is due to the community support that has been put in place, as part of the ISVA's interventions.

Table 12: Referrals to Support Services



8.10 Since April 2020, the HISVA has:

- The service won the HRH Integrated Approaches to Care, Nursing Times Awards 2020
- The service was a finalist at Patient Safety Awards 2020, NHS Safeguarding Initiative
- Trained over 260 staff in sexual abuse awareness
- Continued to create strong links with the AED department to equip staff to respond to the disclosure of sexual abuse.
- Collaborated with the Sexual Health Service to develop and implement the sexual abuse proformas.
- Supported the roll out of the Safeguarding Ambassador's campaign by developing a training package and undertaking the delivery of training in regard to sexual and domestic abuse.
- Completed the Lime Culture Independent Sexual Violence Adviser Course, achieving 100% in all 6 modules.
- Completed the Independent Domestic Violence Adviser Course.
- Quality assuring risk assessments and making appropriate referrals for victims of domestic abuse.
- Supported the Trust during the Pandemic by supporting the Safeguarding Team with domestic abuse cases, the quality assuring of DoLs, aiding the 'Letter to loves ones' service, supporting the bereavement service, and organising hospital donations.

8.11 Feedback from training

When attendees were asked for the overall rating of the session, 100% were very satisfied.

- "It was useful to become more aware of forms of domestic and sexual abuse, and how to fill in documentation and ways to ask questions to get more information".

- “I really enjoyed today. This session is not a subject that people are comfortable with, but this opened my eyes to it a lot more”.
- “Knowing the correct procedures for raising disclosures of sexual abuse”.

8.12 Feedback from staff following Health ISVA support

- “Thank you so much for the feedback. It is useful to see what you have put in place for her. “Thanks for your help and speedy response”.
- “This is incredible! I can’t thank you enough for this Faye”.
- “You have been very helpful and supplied her with lots of support”.

9.0 DOMESTIC HOMICIDE REVIEWS (DHR’s)

9.1 There have been 3 requests for information in relation to DHR’s in Sefton and the Trust has provided information in relation to one of those cases. The Trust is involved in 1 of these DHR’s, and will be providing the relevant attendance for panel meetings.

10.0 SERIOUS CASE REVIEWS (SCR) and CHILD SAFEGUARDING PRACTICE REVIEWS (CSPR’s)

10.1 The Named Nurse for Children’s Safeguarding attends the Lancashire Safeguarding Practice Review Business Meeting, and the Sefton CSPR Group as requested. The Assistant Director of Safeguarding and the Named Nurses attend and support both SAR and CSPR panel reviews for both Lancashire and Sefton, as requested.

10.2 A children’s Safeguarding Practitioner is currently on the panel for an CSPR, and whilst the Trust was not directly involved with the child, appropriate learning will be shared by the CSPR panel following the review. Following this the Safeguarding Team will identify any internal actions required.

10.3 This year the Trust has been required to provide information for rapid reviews in relation to 8 children. One has resulted in the Trust involvement in a learning Review.

10.4 Members of the safeguarding team and clinical staff have also attended a practitioner learning event in relation to a local learning review; actions from this review are being followed up and learning will be shared as appropriate. The Safeguarding Team will apply any learning ensuring these are included in level 3 children’s training, and processes and policies updated, as required.

10.5 Learning from further CSPR’s will be shared via the LSCB/CSAP’s and the Learning and Development Subgroups, where the Trust provides representation.

10.6 The Named Nurse for adult safeguarding is a member of the Lancashire SAR review group, although this group in its current format was disbanded in Q3 2020. As such referrals are submitted to the LSAB, who triage and decide if to undertake a local panel to complete the SAR. The Named Nurse Adults fulfilled the role of independent chair for Adult L, reported under the Lancashire Adult Board SAR process. The final report was shared with the LSAB in January 2021 and is currently awaiting publication. The Named Nurse Adult is currently fulfilling the role of independent author for SAR’s 7 and 8, on behalf of the Merseyside SAB.

10.7 The Trust has not been required to provide information to support any SARs in 2020/2021.

10.8 The Safeguarding Team review all learning from Lancashire and Sefton SARs and CSPR's, and as a result will adapt processes and policies, documentation, training and share information to relevant staff.

11.0 MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

11.1 The Mental Capacity Act 2005 (MCA) is an integral piece of legislation used by healthcare professionals.

11.2 In 2009, DoLS was bolted onto the MCA 2005 in order to create a procedure enshrined in law to deprive people, who are assessed as lacking capacity, of their liberty (in their best interest). In 2014, the case 'Cheshire West' created the acid test to enable practitioners to define whether a person is deprived of liberty. Under the acid test, any patient over the age of 18, who lacks capacity to consent to their arrangements (i.e. admissions to hospital), who is subject to continuous and effective supervision and control and is not free to leave, is defined as 'deprived of liberty,' and therefore a DoLS is required to safeguard their human rights. The impact for an acute Trust is that all patients who lack capacity and are in the acute hospital setting as an in-patient, require a DoLS authorisation.

11.3 This poses a challenge not only to S&O as an acute trust but has also placed a heavy burden on the Supervisory Body (Lancashire and Sefton's County Council), who are required to complete Best Interest Assessments and authorise a significant number of DoLS in the community, as well as the hospital setting. As a result the Supervisory Bodies have been unable to meet the need, and therefore a number of patients remain deprived of liberty without any legal authorisation. As a result, after 14 days patients are deprived of their liberty under the principal of best interests. As in previous years this situation has remained for this year and remains escalated through to the LSAB's. The situation has been further hampered by the pandemic and the visiting restrictions imposed, that have prevented the best interest assessors attending the site to undertake the best interest assessments.

11.4 This is detailed in the Trust risk register which refers to patients who are placed under an urgent 14 day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

11.5 To mitigate the risk the Safeguarding team have developed a robust system for monitoring the DoLS process: all datix checked; all DoLS applications quality assured; if required the application is re-submitted to the Supervisory Body, if information is missing or incorrect; revised applications are emailed back to the ward in order for it to place in the patient's clinical record. Ward staff are required to review and record on a daily basis the restrictive practices in place to ensure these are the least restrictive and proportionate.

11.6 A spreadsheet is maintained detailing the expiry dates of the urgent and standard authorisations. This is enhanced by a DoLS proforma in Medway. The team sends an email regularly to the Supervisory Body, advising of patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the team is aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest

Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

11.7 This year has seen a 26.7% increase in the number of referrals for a DoLS authorisation to 1433, (Table 13).

- 882 Sefton
- 540 West Lancashire
- 12 Other

11.8 Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who have deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body, (Table 14).

11.9 The team strive to achieve 100% compliance for all patients who meet the criteria for a 2-stage capacity assessment, and for a DoLS authorisation. The team have collaborated with IT colleagues to begin development of a DoLS portal, which will allow the electronic completion of the 2-stage capacity assessment, and the DOLs authorisation. This has allowed safety nets to be added such as, not being able to complete the 2-stage capacity assessment if the assessor cannot identify the impairment of mind or brain.

Table 13: Deprivation of Liberty Safeguards Applications

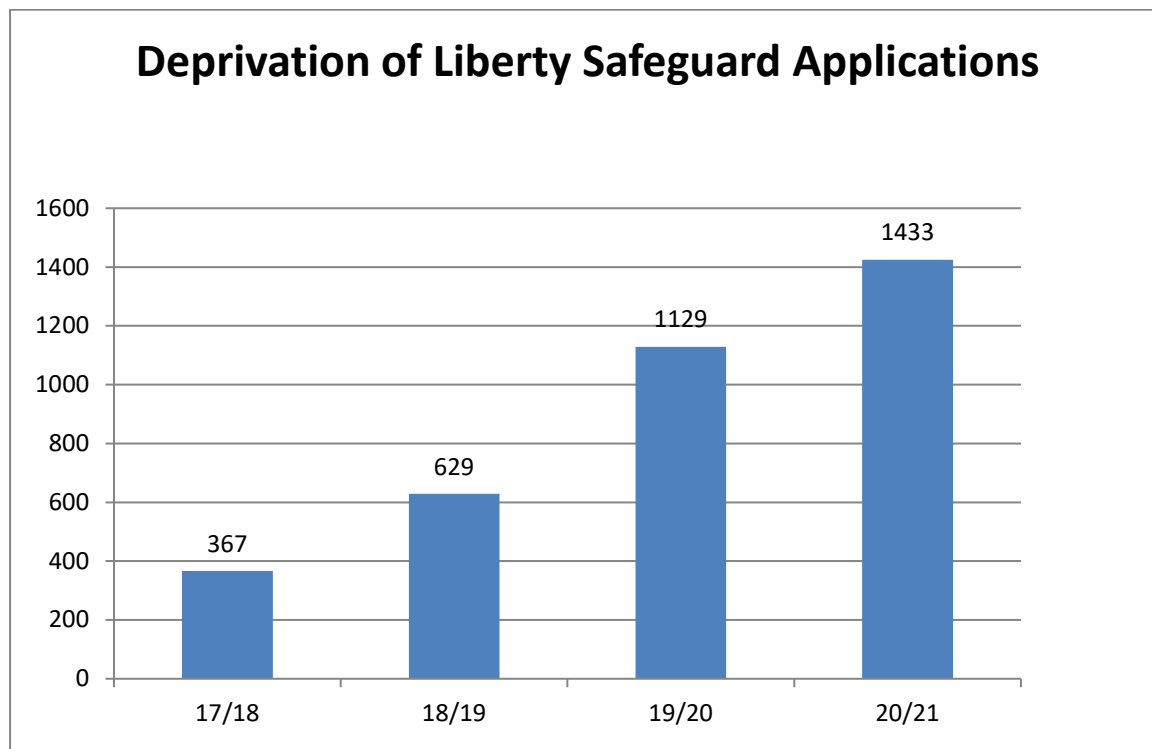
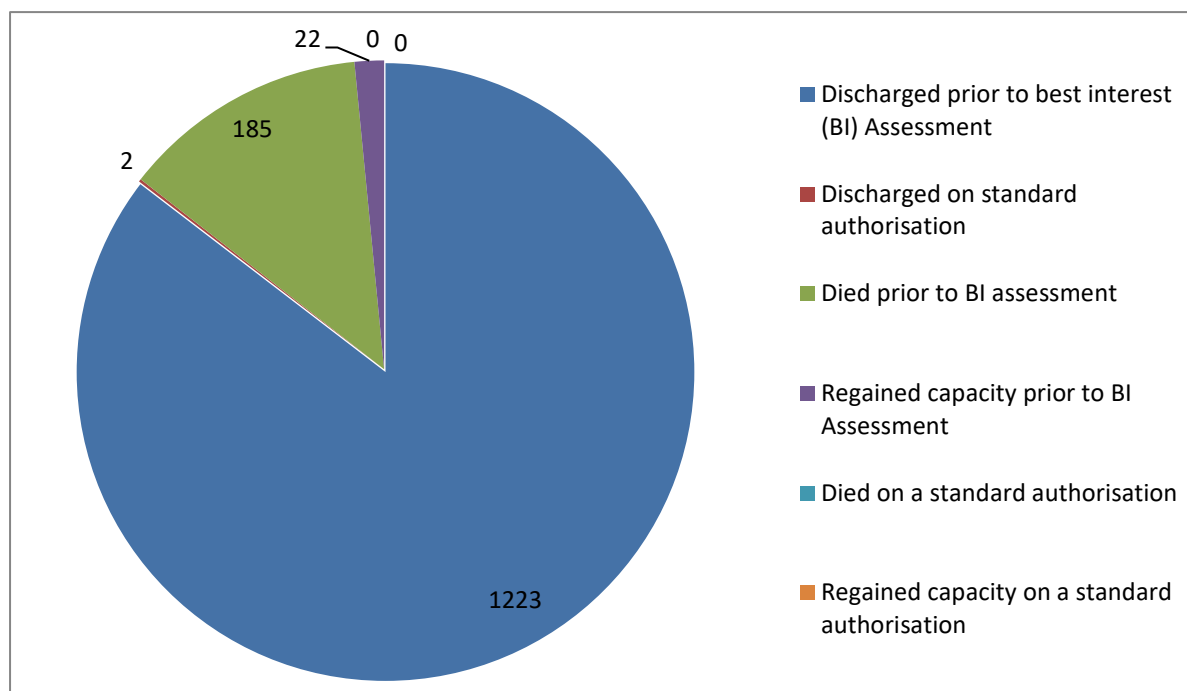


Table 14: Outcomes of DoLS Applications



11.10 Liberty Protection Safeguards (LPS)

11.11 In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards, (although the term is not used in the Bill itself). The target date for implementation was spring 2020, later revised to October 2020, and due to the pandemic has been extended to April 2022.

11.12 Key features of the Liberty Protection Safeguards (LPS) include:

- In line with the Law Commission’s suggestion they start at 16 years old.
- Deprivations of liberty have to be authorised by the ‘responsible body’. For NHS hospitals, the responsible body will be the ‘hospital manager’.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
 - The person lacks the capacity to consent to the care arrangements
 - The person has a mental disorder
 - The arrangements are necessary to prevent harm to the cared-for person and are proportionate to the likelihood and seriousness of that harm.

11.13 The LPS will have significant implications for acute NHS Trusts, as the authorisation of the LPS will be the responsibility of the hospital and not the LA, as in the current arrangements. It is unclear how the new LPS will affect the number of applications, as a result of the inclusion of 16- and 17-year-olds. NHS E/I have confirmed they will develop a number of training packages for the implementation of LPS.

11.14 In light of the pandemic the implementation date was postponed from April 2021 to April 2022. This remains the expected date for implementation, and the current situation remains that all partners are awaiting the publication of the Code of Practice, due spring 2021, after which there will be a 12-week public consultation. The Code of Practice will inform partners to

their statutory responsibility, and this will enable a mapping of the resources that will be required in order to fulfil these new statutory responsibilities. It is highly anticipated that a formal business case for additional staffing will be required.

12.0 JOINT TARGETED AREA INSPECTION (JTAI) OF THE MULTI-AGENCY RESPONSE TO CHILDREN'S MENTAL HEALTH IN SEFTON.

12.1 Between 23 and 27 September 2019, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMIP) carried out a joint inspection of the multi-agency response to abuse and neglect in Sefton. This inspection included a 'deep dive' focus on the response to children's mental health. Inspectors focused on children's mental health and on how partners identify children who also need help and protection. Included was a 'deep dive' focus on children identified as being in need who have a range of emotional well-being and mental health needs.

12.2 Following the review South Sefton CCG established a task and finish group for all partners to develop a joint action plan, (Table 16). The Assistant Director of Safeguarding and the Children's Named Nurse has provided representation at the group. The children's team have collaborated with colleagues both internally and externally to address the recommendations of the report, (Table 15). During this year the task and finish group closed with the understanding that were required on-going evidence of assurance would be provided as necessary. All actions identified for the Trust have been completed.

Table 15: Practise noted at Southport and Ormskirk NHS Trust

There is also consistent oversight of children's attendances at Ormskirk hospital by paediatric liaison
In addition, there is effective, routine and consistent child protection information system checks at Ormskirk hospital
Staff at Ormskirk Hospital benefit from proactive case discussions with the safeguarding team that reflect on the clinicians' practice and appropriately identify whether additional actions are required to meet the child's needs
Emergency department staff at Ormskirk hospital appropriately seek ad hoc guidance and support from their safeguarding teams in order to support their decision-making.
The use of an agreed dedicated risk assessment tool to help identify children who may have poor mental health and who self-harm is not embedded in the paediatric emergency department at Ormskirk District General Hospital
Ormskirk District General Hospital has a different process to Alder Hey when recording MASH outcomes and this was considered inconsistent.
Leaders at Ormskirk District General Hospital report that the absence of a 24-hour crisis mental health team has resulted in some children being admitted to hospital who might otherwise have been safely discharged home with CAMHS follow-up. Furthermore, while staff in the emergency department have accessed the psychiatrist at Alder Hey children's hospital out of hours, there were no established procedures or pathways to underpin this practice

Table 16: JTAI Actions for Southport and Ormskirk NHS Trust

Ensure Southport and Ormskirk Accident and Emergency Department are aware of referral to on call psychiatry and Crisis Team cover	Staff are aware of the referral process	
Information sharing on children records with outcomes from the MASH will be consistent across secondary care providers where Sefton children access services	Assurance provided that process at the Trust is appropriate	
Southport and Ormskirk will introduce a risk assessment to be introduced to AED to help identify children who have poor mental health and who self-harm	Assessment tool in place	
Southport and Ormskirk to review the AED documentation to ensure that it is fit for purpose	Audits of the AED documentation is on-going	
Southport and Ormskirk Trust will include voice of the child and professional curiosity in level 3 training. Southport and Ormskirk to ensure all staff are aware as opposed to level 3 training	Evidence of the voice of child provided	

13.0 PREVENT

13.1 Prevent is part of the Government's counter terrorism strategy, and as the name suggests it is the part of the strategy designed to identify people who may be vulnerable to radicalisation, before they commit any crime. It therefore operates in the pre-criminal stage and essentially requires professional groups, particularly in the public sector, to be aware of the signs that an individual may be being radicalised, and then to refer such concerns onto the proper authorities to make the necessary interventions. Local Authorities, Health, Education and the Police amongst others form the CHANNEL Panel, which considers every case referred, and determines which professionals should be engaged to intervene in addressing the individual's needs. The Named Nurse Adult has secured the only health representation at the Sefton CHANNEL Panel Group.

13.2 All Prevent training is on-line and is available to all staff through ESR. There remain 2 tiers of training aligned to staff role. All new staff receive a Prevent awareness leaflet in their welcome pack, and this is also available on the Trust intranet.

Table 18: Prevent Training Compliance

	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Prevent Awareness	97%	97%	97%	95%	80.1%	88.3%	91.9%	92.8%
Prevent WRAP	89%	90%	90%	88%	85.2%	86.6%	87.9%	86.4%

13.3 The Trust has made no PREVENT referrals this year.

14.0 MANAGING ALLEGATIONS

14.1 There have been 13 cases of allegations raised, although not all are in regard to Trust staff. The Trust made 3 referrals to the Local Authority Designated Officer (LADO), although one did not involve Trust staff. In all cases the allegation was investigated appropriately, and this year the policy for Allegations Against People in Positions of Trust, has been revised and will support the allegation process moving in to next year.

15.0 SAFEGUARDING AUDITS

15.1 The safeguarding team have undertaken a number of audits this year including:

Completion of safeguarding documentation for adults attending Adult AED
Use of the under 18 AED card
Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm (19-003)
The quality of children's social care referrals from Paediatrics, Maternity and adult AED referrals
Quality of child protection medicals
Maternity Did not Attend compliance
The quality of adults safeguarding referrals
The quality of domestic abuse referrals
The completion of MCA and DoLS documentation
Learning Disability Process

Quality of adult referrals audit.

This audit has offered significant assurance. The required area for improvement is asking if the patient has any dependants, which achieved 40% compliance. The safeguarding team reviewed the referral form, and when we move to a digital solution this will be a mandated question.

Quality of Children's referrals audit.

This audit offered significant assurance. Completion of a good referral continues to be taught in level 3 children's training. The referral process is being reviewed with all referrals being quality assured by the safeguarding team.

MCA knowledge transfer audit.

This audit offered limited assurance. This was a result of the below 2 questions.

- Is the staff member able to identify all the 5 principles of the mental capacity act?
- Can the staff member identify what constitutes a deprivation of liberty?

Staff were able to identify some of the principals of the MCA, and or 1 of the elements of the acid test, but to achieve a 'yes' staff had to answer all 5 principals and both elements.

Subsequent actions to date have included:

- Full day MCA awareness days being delivered and repeated.
- The training delivered on the older peoples training has been revised
- Face to Face MCA training will be delivered to the Foundation Doctors in July
- New credit card size cards have been produced in regard to MCA principal, and will be disseminated to staff
- The team will undertake an audit of all acute wards in regard to the 2 stage assessment and DoLS in place, and this will be presented at the Ward Managers meeting when completed.

PAED Documentation Audit

This audit offered significant assurance. Currently the AED card in the department is being revised.

AED <18 Documentation compliance audit

This audit offers limited assurance. There is a positive improvement in CP-IS being accessed, evidence of the voice of the child and plans being shared with the young person. There is an improvement in dependants being considered, although this needs further improvement. The action plan includes working with AED staff to increase the awareness of the importance of providing certain information; a review of the under 18 CAS card, and a review of the audit question set.

Maternity Did Not Attend SOP Compliance Audit

This audit has offered full assurance that Midwives are following the revised SOP.

16.0 COMPLAINTS

16.1 There has been 1 complaint received on 31st March 2020. This relates to the patient being dissatisfied with a referral to children's social care. This has been investigated and the referral is upheld, and was made in accordance of policy. The response involved the Assistant Director of Safeguarding speaking directly to the complainant to address the concerns raised.

17.0 COMMISSIONING STANDARDS

17.1 The Trust submits a quarterly update to South Sefton CCG as part of the KPI submission. Due to COVID and business continuity planning, there has been no requirement to submit 'commissioning standards' evidence as would have been anticipated in Q1. The requirement has been for an updated commissioning standards action plan to be submitted each quarter, to demonstrate progress against the action plan developed against the previous self-assessment.

Commissioning Standards	Assurance Required
The organisation has effective allegation policies and systems in place for professionals and service users, which is compatible with MASA/LSAB Procedure and Guidance, including guidance on Person in a Position of Trust (PiPoT) guidance	The revised policy has been through the necessary policy ratification processes and is available on the intranet
The children's policy and procedures have been reviewed since the introduction of Working Together 2018 and are Care Act 2014 compliant and includes reference to NICE guidelines (NG75 & CG89)	The revised policy has been through the necessary policy ratification processes and is available on the intranet
Subcontracted/ commissioned services by the organisation who work with Children and are delivering statutory services are Section 11 compliant and have been audited. Other contracts require the organisation to achieve Safeguarding Standards, which are the same as those for Section 11.	There are no services identified that provide statutory services
Development and introduction of a policy that includes all the below elements: Restraint used is documented, followed by assessment for signs of injury, emotional or psychological impact in line with policy.	The policy has been developed and after following the policy ratification process has been published on the intranet.
Review of operational safeguarding strategy and dissemination of any changes	The strategy has been developed and is awaiting

18.0 RISK REGISTER

18.1 There are 2 risks relating to safeguarding in 2020/21:

DoLS- Lancashire Local Authority is not undertaking Best Interest Assessments; therefore, the Trust may be depriving patients of their liberty without the necessary legislation in place. This has been escalated via the Lancashire Safeguarding Board, and the Local Authority has a process for prioritising their waiting list. This has been mitigated as detailed in 11.5 and 11.6

18.2 The Trust does not have a clinical photography team; as a result photographs provided by the Trust for the purpose of child protection and criminal investigation processes, and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. The Trust has procured the 'connect' system which should be able to mitigate this risk and remove the risk from the risk register. Whether this provides a viable solution will be reviewed in the next year.

18.3 An additional risk that may require adding to the risk register in 2021/22 and will only be determined on the publication of the LPS Code of Practice.

- The Trust does not have the resources to meet its obligations under the new LPS arrangements; therefore, patients may be deprived of their liberty without necessary legislation in place.

19.0 WORK PLAN 2020/2021

- Plan and prepare and recruit in preparation for the implementation of the LPS process, ensuring the Trust meets its statutory obligations
- Developmental and commencement of a Service Level Agreement with MerseyCare to provide a Mental Health Administration Service.
- Implementation of the MCA and DoLS portal
- Implementation of the electronic safeguarding adults referral form
- Ensure the 'connect' solution meets the requirements for safeguarding
- Achieve adherence to the S42 Memorandum of Understanding
- Implementation of the new 'Care of 16 -17 year olds in an Adult Hospital' SOP
- Continue to improve the completion of the safeguarding documentation in AED
- Continue to ensure the development of a network of safeguarding ambassadors
- Achieve training compliance ensuring compliance to the intercollegiate documents
- Ensure compliance to the 'All Age Restrictive Practise' Policy
- Publish the 'Managing Allegations against People in Positions of Trust' Policy
- Implementation of all revised policies
- Make the decision to the implementation the 'graded neglect care tool for antenatal care' currently being trailed by one of the partners of the CSAP in Lancashire.
- Support the Sefton partnership with the subsequent action plan following the publication of the Ofsted visit undertaken in 2021.

- Recruitment to the vacant post of the Safeguarding Administrator
- Streamlining the children's databases to ensure relevant and accurate data is available.
- Continue to facilitate training for the partnership via the training pool.
- Implementation of revised safeguarding referral forms for Lancashire
- Implementation of the New Model of Working Well with Families in Lancashire
- Continue to support with relaunch of CFWS (Lancashire) and Early help offer (Sefton)

20.0 CONCLUSION

20.1 Progress continues to be made in the journey towards safeguarding being embedded in to practice and considered everyone's business. The team work operational within the Trust and engage extensively with external partners as expected, given the nature of safeguarding being a multi-agency and multi-professional practice.

20.2 The Safeguarding team over see and monitor key areas to ensure appropriate referrals and actions are made in order to safeguard the un-born, children, young people and adults at risk of abuse. The challenge continues to be to engage all Trust staff to appreciate the important role they play in recognising and responding to safeguarding concerns within an acute setting, where often the focus remains on the physical well-being of the patient. The safeguarding team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are made, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

20.3 The pandemic of this year has resulted in changes in practice amongst our multi-agency partners. It is expected that both for safeguarding and for the Trust new ways of working will develop and continue over the forthcoming year, and we must ensure that safeguarding is considered at all stages of change.

21.0 RECOMMENDATIONS

21.1 The Board is asked to recognise the achievements made by the Safeguarding Team this year outlined in the report and agree the suggested next steps for the year ahead.

22.0 CASE STUDIES

22.1 The 4 case studies below provide examples of the role of the safeguarding team and value in safeguarding the un-born children, young people and adults at risk of abuse.

Case 1 – Situation

An adult male presented at AED from the West Midlands area. He had travelled to Southport via taxi stating he was fleeing domestic abuse citing his parents as perpetrators. He had Asperger's and severe OCD and was a very vulnerable young man.

Following several phone calls to services in the West Midlands including the police and his social worker, a different picture emerged of a family in crisis, in which he was cited as the perpetrator of abuse against his parents.

He was finding the current Covid restrictions extremely difficult which exacerbated his anxiety and OCD. As a result of the Covid restrictions in place in West Midlands he had been left without an accurate assessment of his needs, both from a mental health and social care perspective. He had previously been sectioned under the Mental Health Act and was subject to Section 117 for after care.

Safeguarding input

The safeguarding team were alerted to this patient when he was refusing to return to the West Midlands, and initial plans to discharge him would have rendered him homeless and vulnerable in an unfamiliar location. The Safeguarding team were instrumental in ensuring multi-agency working between the two Local Authorities and Mental Health services.

The Safeguarding team also challenged and escalated accordingly as discharge plans were being made. The safeguarding team arranged strategy meetings, supported the ward to manage his challenging behaviour, and accompanied him off the ward for walks during the day. The safeguarding team provided lines of communication between the patient, his family and agencies involved in supporting him.

Despite his Asperger's and OCD a 2 stage capacity assessment determined that he had capacity to decide his own discharge destination, but it was recognised by the safeguarding team that he did not have the executive function to maintain his own safety, and to meet his basic care needs in the community. In order to further support the patient the safeguarding team facilitated an escorted visit to a supported living establishment, in the Sefton area.

Due to an exacerbation of his OCD and inability to tolerate the stresses invoked by an in-patient stay the patient absconded on two occasions. As a result the safeguarding team were instrumental in devising and sharing a management plan, to ensure that the patient would be supported appropriately should he return to either locality. This plan was agreed between the two Local Authorities and his local health care provider. Throughout his month long stay the safeguarding team were on hand at all times, even providing support out of hours to ensure that staff were able to meet his needs.

Outcome / Result

The patient was safely transferred to his local AED where he was met by his Mental health social worker in order to arrange appropriate accommodation and support.

Case 2 – Situation

Patient A was a 22 year old female patient who presented at AED due to feeling low in mood following a sexual assault. Patient A appeared very vulnerable and nursing staff queried if the patient had an undiagnosed learning difficulty or disability. The Health ISVA (Independent Sexual Violence Adviser) was alerted to the situation via a Datix and sexual abuse referral form completed by AED staff.

Safeguarding input

When the Health ISVA attended AED, the Police were in attendance and taking a report from the patient. The incident had been reported to the Police by the patient's friend. The patient was very withdrawn, low in mood and didn't respond to any questions asked. The Police were struggling to obtain a statement due to communication issues. The Health ISVA spoke with the patient to identify if she wanted to converse with the police and if there was anything that could help support this communication. When attempting to communicate with the patient, it was apparent that she struggled to verbalise her thoughts and answers.

To improve communication, the Health ISVA asked the patient a question, wrote it down, and then gave the patient the opportunity to write down an answer. The patient was able to communicate and used this form of communication to provide a statement to the police. When communicating with the patient, she stated that she did not want to go home as she was being bullied by flat mates. The patient disclosed that she was recently raped in Liverpool. It was apparent that the patient was vulnerable, for instance, the patient states she overdosed by ingesting x2 500 gram paracetamol tablets.

The patient was referred to the Mental Health team due to her vulnerabilities and recent overdose attempt. The patient was deemed fit for discharge, however the patient did not want to return home due to incidents of bullying. The patient was admitted overnight due to her vulnerability. The Health ISVA liaised with the patient, nursing staff and the police to organise an appointment at the Sexual Assault Referral Centre.

The Health ISVA raised a Safeguarding with West Lancashire Local Authority due to concerns regarding the patient's vulnerability, rape and bullying. The rape was also reported to Liverpool Local Authority; given this is where the rape took place. The Health ISVA also liaised with the patient's University Wellbeing Team to ensure all risks would be considered, and the relevant support would be provided.

With consent, the patient was sent an email with support guidance and referred to Lancashire Victim Services for further sexual violence support in the community.

Outcome / Result

Following the referrals to the Local Authority, the patient was assigned a mental health social worker, resulting in a 'care support needs' assessment being completed. After the interventions of the ISVA the patient was admitted to Royal Blackburn Hospital Mental Health Unit, which provides 24 hour care and subjective treatment plans.

Case – Situation

Child aged 6 years attended PAED. Mum is Portuguese and does not speak English, and the partner (not child's father) is also Portuguese, although speaks English.

The child required a PEG for feeding but this had been dislodged, and the child subsequently had no food and or hydration since the day before. On attendance the child appeared developmentally delayed, although mum did not report this. Mum and the partner were also unclear regarding the child's past medical history. They reported being in England 6 months, but had not been under any care since arriving here.

On presentation there was a clear development delay, as the child was unable to sit and or communicate, this was accompanied by a very low weight.

The child was transferred to Alder Hey to re-insert the PEG, and later he was transferred back to ODGH.

Safeguarding input

Due to lack of history, lack of medical input, a low weight, lack of clarity re his dietary requirements and a potential neglect of medical needs, a referral was made to Children's Social Care.

A subsequent strategy meeting was arranged. It was agreed that there were concerns re medical neglect and not being registered with a GP, mum not knowing how to address the child's needs, the property being unsuitable, living in a house of multi occupancy with nowhere for child to move about, no toys, no equipment.

Mum had provided documentation from Portugal regarding his special needs but did not provide this until a later date. The partner had stated that child was almost removed at birth; as such this required further exploration. A S47 enquiry was agreed in order to seek an interim care order. There were concerns that as a result the parents may flee country, so staff were advised to remain vigilant and do not allow the child to be removed from ward.

The parents and child were monitored in relation to their care and interaction with each other. With some support mum started to address some of his care needs, and a good interaction between mum and child was reported.

Outcome / Result

A full assessment of needs was undertaken with the involvement of occupational therapy, physiotherapy, the complex discharge team, Neurorehabilitation Occupational Therapist. Referral to SALT and for a wheelchair, specialist bed and hoists to be obtained.

The child was placed on an interim care order and it was agreed that child would go to a residential placement in order that his care needs could be met.

The placement was out of area, although Social Care arranged accommodation for mum in order for her to visit, and it was reported that mum visited child regularly.

Mum has subsequently become pregnant and is now under ODGH for her maternity care.

Case – Situation:

A woman was booked for second pregnancy. A previous child was in the care of maternal grandparents, as the mother was unable to safeguard him. The mother was a victim of domestic abuse from the father of the unborn, and throughout the pregnancy there were

several police reports in regard to this shared. This was despite the mother claiming to have no contact with the father, and that bail restrictions preventing contact were in place.

There was a history of cannabis use and housing issues. The mother was due to move into a shared housing arrangement temporarily because of DA and address was not to be disclosed.

At ante-natal booking the mother was reported to struggle with reading and spelling.

Safeguarding input

The Social Worker of the older child was informed immediately to inform them of the new pregnancy. Alerts were added to the woman's maternity record to inform staff to document who attends with her at her ante-natal appointments, and to subsequently inform the Named Midwife.

A referral to CSC was completed after the dating scan, and a domestic abuse risk assessment (DASH) was completed. The woman already had IDVA, so they were informed of her new pregnancy.

The woman was moved to refuge in Preston at 19 weeks, and information with the Social Worker and Named Midwife in Preston was shared.

The woman attended ODGH for her 20 week scan accompanied with the father of the unborn. During this visit there was an incident in car park and police attended; the social worker was informed immediately.

The woman attended SDGH AED following another DA incident when she should have been in the refuge in Preston. The Police returned her to refuge and the incident was shared with her Social Worker and IDVA, and a referral to MARAC was completed.

At this point the woman was moving to Blackburn so the Consultant was informed, and all information was shared with the Named Midwife in Blackburn.

Our Named Midwife attended 2 weekly core groups meetings with colleagues at Preston and Blackburn, as after moving the woman did not register for further maternity care, and there was concern she was no longer being reviewed and or seen.

At 34 weeks the woman moved back to Southport, and was again under the care of ODGH, although she had not received any antenatal care since her scan at 20 weeks, and she had not registered with GP in any locality. An urgent scan appointment was arranged by the Named Midwife.

At this point the woman denied being in a relationship (partner now in prison) but requested he was present for delivery. This request was denied by Named Midwife and the Social Worker, due to the known risk.

Throughout pregnancy the Named Midwife built a relationship with the mother both face to face and over the telephone, which allowed for some open and honest conversations. The

Named Midwife encouraged her to attend the maternity unit, when at 36 weeks there was a complication and she refused to attend when advised to do so by triage.

The Named Midwife informed the Social Worker of the date for induction. At this point foster carers had been identified and a risk assessment was completed by the Named Midwife.

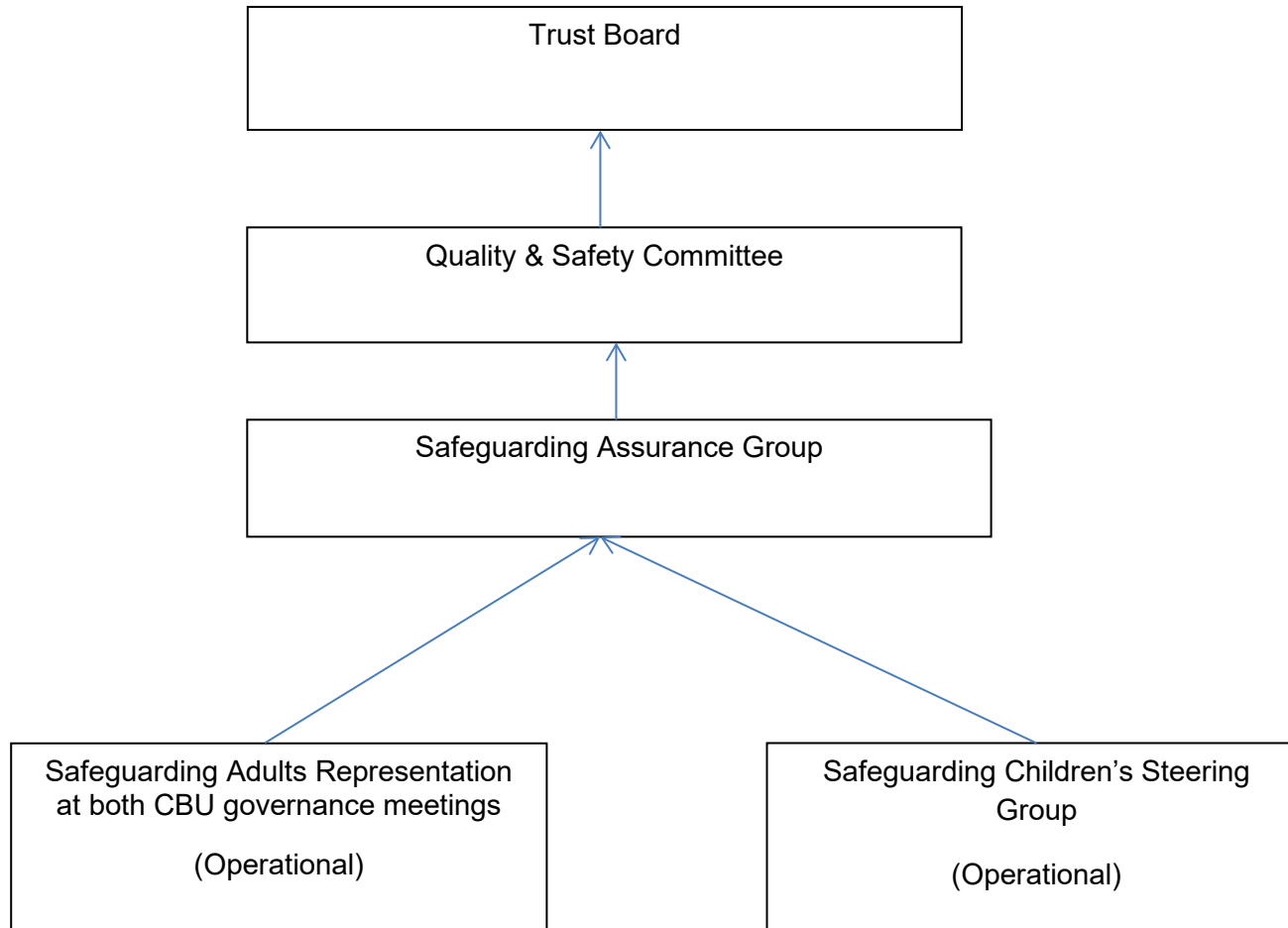
Outcome / Result

The Named Midwife visited the delivery suite when the woman was admitted for induction. At this time she had no birth partner and was very anxious. At the request of the woman the Named Midwife stayed with her during labour and delivery, and acted as her birthing partner. In order to safeguard the baby they were transferred to the neo-natal unit following delivery. An interim care order was granted the following day and the baby was discharged to foster care from the neo-natal unit.

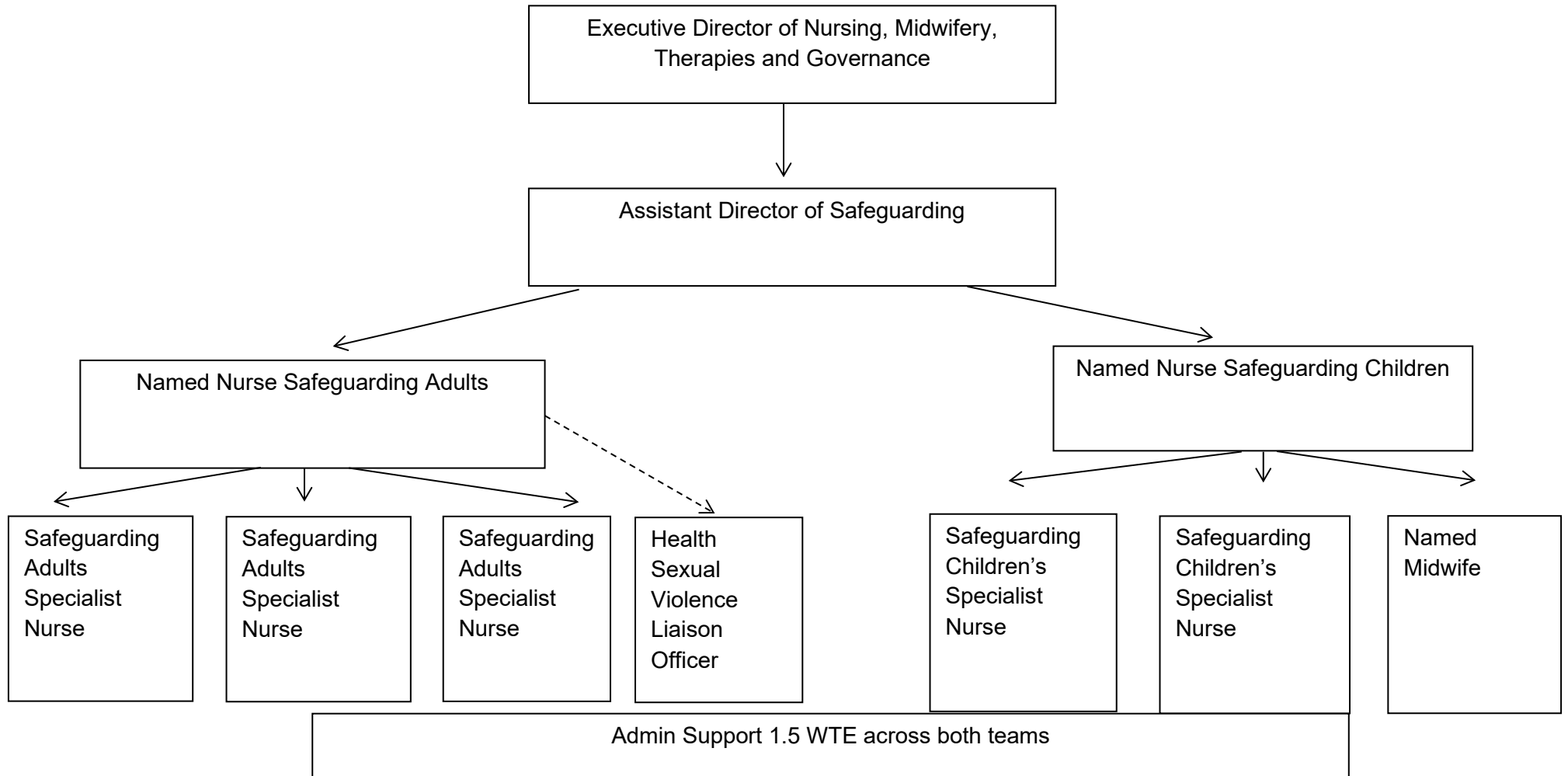
Appendix 1: Glossary of Terms

AED	Accident and Emergency Department
ASC	Adult Social Care
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CE	Child Exploitation
CP	Child Protection
CQC	Care Quality Commission
CP-IS	Child Protection Information System
CSC	Children's Social Care
CSAP	Children's Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review
DBS	Disclosure and Barring Scheme
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
ESR	Electronic Staff Records
FGM	Female Genital Mutilation
GMC	Greater Medical Council
HSVLO	Health sexual violence liaison officer
ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspection (Ofsted, CQC, IPCC)
KPI	Key Performance Indicator
LD	Learning Disability
LA	Local Authority
LADO	(Local Authority) Designated Officer
LPS	Liberty Protection Safeguards
LSAB	Local Safeguarding Adult's Board
LSCB	Local Safeguarding Children's Board
MACSE	Multi Agency Child Sexual Exploitation
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MHLT	Mental Health Liaison Team
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NHSI	NHS Improvement
NMC	Nursing and Midwifery Council
RAG	Red / Amber / Green
Section 42 Inquiry	Safeguarding Adults investigation coordinated by the Local Authority

Appendix 2: Governance Arrangements



Appendix 3: Southport and Ormskirk Trust Safeguarding Structure 2017



Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 OCTOBER 2021
Agenda Item	SO006/21	FOI Exempt	NO
Report Title	MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT 2020 - 2021		
Executive Lead	Dr Kate Clark' Executive Medical Director /Responsible Officer		
Lead Officer	Mr Kevin Thomas, Deputy Medical Director/Clinical Medical Appraisal Lead		
Action Required	<input checked="" type="checkbox"/> To Approve <input checked="" type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input type="checkbox"/> To Receive	
Purpose			
<p>The purpose of this paper is to assure the Committee that appropriate processes are in place to ensure that the Trust is compliant with its legal obligations as per 'The Medical Profession (Responsible Officers) Regulations 2010' (amended 2013) and continues to provide a robust medical appraisal and revalidation system.</p> <p>All responsible officers have been requested to present an annual report to their Board, using 'The Framework of Quality Assurance for Responsible Officers and Revalidation' (FQA) template and submit a 'Statement of Compliance' to the Higher-Level Responsible Officer at NHS England.</p>			
Executive Summary			
<p>As at the end of the appraisal cycle on 31 March 2021, the Trust was the 'designated body' for 222 doctors. Medical appraisal was formally suspended by NHSE in March 2020 due to the pandemic, leaving the decision to individual RO's whether to continue. The Trust did not suspend medical appraisals but gave doctors the option of completing, albeit later than scheduled in some cases, or requesting an 'Approved Missed Appraisal' for the year. Medical appraisal was formally restarted in October 2020 by NHSE/GMC. 60.36% of doctors completed a medical appraisal in the required timescales in line with GMC requirements. The reasons for late, incomplete or missed appraisals are as below:</p>			
	2018/19	2019/20	2020/21
Appraisals completed	183 (92.90%)	166 (83.5%)	134 (60.36%)
Approved missed or late appraisals - sickness/maternity	6 (3.05%)	5 (2.5%)	5 (2.25%)
- other/new doctors	6 (3.05%)	0	28 (12.61%)
Approved late appraisals completed - (COVID)	N/a	24 (12%)	12 (5.4%)
Approved missed appraisal not completed - (COVID)	N/a	4 (2%)	42 (18.91%)
Unapproved missed or late appraisal (i.e.not authorised by RO)	2 (1.00%)	0 (0%)	1 (0.45%)
TOTAL	197	199	222
Recommendations			
<p>The Board is asked to approve the contents of the report and sign off the 'Statement of Compliance' for forwarding to NHSE.</p>			
Previously Considered By:			
<input type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee	<input checked="" type="checkbox"/> Quality & Safety Committee <input type="checkbox"/> Workforce Committee <input type="checkbox"/> 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	
<input type="checkbox"/> 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	
<input type="checkbox"/> SO6 Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	Presented By:
Ann Higgin, Appraisal & Revalidation Manager	Dr Kate Clark, Executive Medical Director



A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

<https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/>

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.¹ This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

- a) help the designated body in its pursuit of quality improvement,
- b) provide the necessary assurance to the higher-level responsible officer, and
- c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

¹ Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board of **SOUTHPORT AND ORMSKIRK NHS TRUST** executive management team can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/a

Comments: Following the retirement of Dr Terry Hankin in June 2021, Dr Kate Clark was appointed the Responsible Officer (RO) for the Trust on 07.06.2021. Dr Clark has undertaken the required RO training programme and has an annual appraisal undertaken by an external appraiser appointed by NHSE.

Action for next year: No changes anticipated.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: N/a

Comments: The RO has sufficient allocated time to undertake the RO role and is supported by the Clinical Appraisal Lead (Mr Kevin Thomas) and the Appraisal and Revalidation Manager (Ann Higgin).

Since electronic appraisals were introduced in 2010 the IT platform used for operating medical appraisal has been the Trust's internal 'SharePoint' system. This has increasingly become outdated as other IT upgrades have been implemented, reducing the functionality of the system and making it more difficult for doctors and appraisers to complete the process smoothly. Therefore if 'SharePoint' is no longer going to be supported, an alternative system, (possibly external) will need to be sourced to enable the medical appraisal process to operate effectively and minimise the administrative burden on doctors.

Action for next year: Alternative appraisal system to be sourced and implemented.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/a

Comments: Revalidation dates are issued to individual doctors by the GMC. It is a legal requirement that an accurate record of all licenced medical practitioners with a prescribed connection to the trust is maintained. The Appraisal & Revalidation Manager receives a monthly report from the HR department, which is cross referenced with the GMC electronic system 'GMC Connect' and makes any

necessary changes. There are also 4 doctors who are not subject to revalidation as they are governed by the General Dental Council (GDC) which does not yet have a revalidation process in place. These doctors still undergo the same annual appraisal and are required to provide the same supporting information as all other doctors.

Action for next year: Continue process

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review policy

Comments: The Appraisal and Revalidation Policy is currently being reviewed. This incorporates appraisal national policy and guidelines.

Action for next year: Confirm policy, publish and communicate

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Consider any other appropriate peer reviews

Comments: A review was undertaken by Mersey Internal Audit in 2014 and a Higher Level Responsible Officer Quality Review with representatives from NHSE in November 2016. Feedback from both was positive. Due to Covid restrictions no peer reviews were identified and organised since the last Board Report. It may be more informative and beneficial if any peer review is now undertaken once a new appraisal system has been sourced and embedded.

Action for next year: Consider any appropriate peer reviews and timescales

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue ongoing support

Comments: All non-training grade doctors holding a contract of employment are supported by the Trust and given the resources to undertake an annual appraisal regardless of whether they are employed as a locum or a permanent doctor. The Risk Department provide information in relation to complaints, claims, incidents suis etc. for all doctors to enable reflection.

Action for next year: Continue ongoing support

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: N/a

Comments: All doctors are required to complete relevant declaration forms concerning participation in any outside work and include supporting information for their full scope of work in their appraisal.

Information relating to complaints, claims and incidents is provided by the Risk Department and made available to all doctors to allow reflection. Where applicable, clinical benchmarking data is also provided, and doctors provide their own specialised data e.g. NJR.

The NHSE revised Appraisal 2020 model was not adopted last year as medical appraisals within the Trust had already commenced when the changes were announced, however doctors were advised that they should only provide what supporting information was easily accessible to them and not to spend copious amounts of time gathering information. The 2020 Appraisal model is being adopted in 20/21 appraisal cycle with more emphasis on verbal reflection and wellbeing.

Action for next year: Continue process

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/a

Comments: The RO is made aware of any doctors who are unable to complete an appraisal for whatever reason and any '*approved missed appraisals*' are required to be authorised by the RO and appropriate records maintained to ensure no detriment to a doctors revalidation.

Action for next year: N/a

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/a

Comments: MED STAFF 14 Medical Appraisal and Revalidation Policy is in place. The policy is currently being updated to incorporate changes in national policy and guidelines.

Action for next year: Confirm policy, publish and communicate

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue to review and train additional appraisers as necessary.

Comments: There are currently 45 appraisers (35 Consultants/4 Associate Specialists/4 SAS doctors and 2 locum consultants). A further 6 doctors will be trained in the next six months to cover for increase in doctors and turnover/retirement of appraisers.

External accredited training is provided for new appraisers and refresher training as required.

Action for next year: Continue to review and train additional appraisers as required.

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

Action from last year: N/a

Comments: Appraisers are required to participate in relevant continuous professional development to maintain their appraisal skills. The trust provides support to appraisers through the 'Appraiser Support Groups' which are usually held at least once a year to discuss topical issues, challenges and share best practice in a confidential environment. There were no meetings in 2020 due to the pandemic but these are planned to restart in the autumn. Group Attendance is monitored and added to the '*Appraiser Quality Assurance and Feedback Record*' issued to each appraiser.

Following completion of their appraisal, doctors are requested to complete an appraisal feedback form. This information is anonymised, and a summary report collated for each appraiser and added to the aforementioned report in order for them to reflect upon in their own appraisal. Any concerns highlighted are discussed with the RO and the doctor and any relevant action taken (e.g. retraining).

Action for next year: Reinstate appraiser support groups and feedback

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

- The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/a

Comments: Internal quality assurance measures including a process for review of appraisal portfolios are in place.

The 'Annual Organisation Audit' (AOA) and 'Annual Board Report' and 'Statement of Compliance' form the basis of reporting to the 'Quality and Safety Committee' before being presented to the Board and then submitted to NHSE. Appraisal completion rates are published monthly.

Action for next year: Continue

Section 2b – Appraisal Data

- The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	222
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	134
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	88
Total number of agreed exceptions	87

Section 3 – Recommendations to the GMC

- Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/a

Comments: All recommendations made to the GMC during the period have been considered and submitted on time.

Appraisal portfolios are reviewed for all doctors by the Appraisal & Revalidation Manager, and/or Clinical Lead/RO to provide assurance that the outputs, declarations and supporting information provided meet the necessary requirements. before the RO makes a revalidation recommendation to the GMC.

Due to the Covid pandemic the GMC postponed a number of doctor's revalidation dates for 12-18 months in order to allow doctors more time to collect the relevant

supporting information and Responsible Officers more time to consider the doctors portfolios.

Action for next year: Continue process

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/a

Comments: Doctors are made aware of all revalidation recommendations prior to submission to the GMC. Any deferrals are discussed with the doctor and a plan of action agreed, documented and monitored.

Action for next year: Continue

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/a

Comments: There are systems in place for reporting and reviewing significant events, complaints and clinical performance. Openness and reporting of incidents is encouraged. This process is managed through the CBU, governance reporting to a serious incident group and a Clinical Effectiveness Committee.

Action for next year: Continue

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/a

Comments: Doctors who have been involved in any complaints, claims, never events etc. are required to include a reflection of the incident in their annual appraisal portfolio. This information is provided to the Appraisal and Revalidation Manager by the Risk department and the data is uploaded into the doctor's appraisal portfolio prior to appraisal, in order that the doctor can ensure that the appropriate reflection has taken place.

Doctors also undertake a 360 patient and colleague feedback exercise at least once in each revalidation cycle (although currently formal patient feedback is difficult to

obtain given the COVID pandemic and how we integrate obtaining this feedback with the wider patient experience across the trust needs to be considered).

Clinical benchmarking data is also provided where appropriate. The Trust has recently changed the system for obtaining clinical benchmarking data from Dr Foster to HED (Health Evaluation Data) created by University Hospitals Birmingham which is used by NHS hospitals across England.

Consultant performance is currently monitored through the CBU and through a regular internal meeting with workforce and quarterly external reviews with the GMC Employer Liaison Advisor

Action for next year: Current RO to review monitoring processes.

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS' (MHPS) is followed.

The RO, Deputy Medical Director and HR Director meet on a monthly basis to discuss any issues (MHPS Meeting).

The RO attends a serious incident report group on a regular basis to monitor overall response to serious incidents in the organisation

Quarterly meetings are held between the RO and the GMC's employment Liaison Advisor to discuss any performance or revalidation issues.

Action for next year: Continue

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.³

Action from last year: N/a

Comments: The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/Senior Medical Management in the organisation as per policy.

In the future analysis of this information needs to be included in the Workforce Improvement Group, reporting to the Board.

³ This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: Include above information for the Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.⁴

Action from last year: N/a

Comments: Relevant RO to RO references are issued and requested. Any immediate concerns are raised by the RO with any other relevant RO in a timely and appropriate manner.

Action for next year: Continue

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/a

Comments: The Trust policy MED STAFF 01 'Maintaining High Professional Standards in the Modern NHS' (MHPS) and other relevant Trust policy are followed.

Action for next year: N/a

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/a

Comments: The Trust has an appropriate procedure in place operated by the medical staffing department, for obtaining relevant information when entering into a contract of employment with doctors for the provision of services.

Permanent, and bank recruitment is audited regularly by MIADD and appropriate action plans put in place should any anomalies require attention.

⁴ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11:
<http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

Action for next year: Continue

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

1. **General review of actions since last Board Report:**

The GMC/NHSE advised in March 2020 that medical appraisals could be suspended if necessary but left it to Responsible Officers locally to determine what action to take. The Trust did not suspend medical appraisal but gave doctors the option of completing, albeit later than scheduled in some cases, or requesting an '*Approved Missed Appraisal*' for the year. Medical appraisal was formally restarted in October 2020 by NHSE/GMC with the appraisal focus being on doctor's health, wellbeing and development and minimising the administrative burden involved in appraisal.

Actions still outstanding:

Medical appraisal policy update

Current Issues:

Outdated internal appraisal IT system

New Actions:

Appraisal and Revalidation Policy review

Source appropriate IT appraisal system

Overall conclusion:

Engagement in medical appraisal continues to be very positive.

Additional Note: QUEENSCOURT HOSPICE

Although Queenscourt Hospice is now a designated body in its own right the Trust continues to provide a responsible officer for the hospice given the small number of doctors employed (4). The hospice is provided with a separate board report and AOA and the Trust provides appraisal support for the hospice under a formal SLA. Two doctors at Queenscourt have been trained as appraisers and act as appraisers for the Trust

Section 7 – Statement of Compliance:

The Board of **SOUTHPORT AND ORMSKIRK NHS** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman)]

Official name of designated body: **SOUTHPORT AND ORMSKIRK NHS TRUST**

Name: _____

Signed: _____

Role: _____

Date: _____

NHS England and NHS Improvement
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ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP	WORKFORCE COMMITTEE
MEETING DATE:	28 SEPTEMBER 2021
LEAD:	LISA KNIGHT

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence

The overall sickness absence rate has remained static in position in month. The highest absence rates are still due to external anxiety, depression and stress and thus the Workforce Directorate are focussing on how the Trust can increase the health and wellbeing of staff to support their attendance. There was a discussion over the importance of focussing on presenteeism as well as absenteeism. Partnership working with Edge Hill University for the Individual Restoration Programme has commenced.

Staff Turnover

The staff turnover rate has increased in month from 1.2% in July 2021 to 1.7%, and the rolling staff turnover rate is still causing concern.

Staff Retention

Whilst staff retention has increased month, the desired target is still not being met.

ADVISE

PDRs

Compliance in PDRs has increased from 76.% in July 2021 to 78.6% in month, however the desired target is still not being met. There have been specific increases in compliances from Specialist Services and Corporate Services which is positive.

Nursing Vacancies

The nursing vacancy rate has remained static in month. International recruitment is continuing to bring nurses into the organisation: 93 have currently joined; 70 of these have passed their OSCEs and 24 are waiting for their Pins.

Bank and Agency

There has been a significant reduction in agency spend in August 2021 which is highly positive in terms of improvement.

Guardian of Safe Working (GOSW)

The GOSW Annual Report allowed the Committee to identify that some staff do not see Exception Reporting as critical to address rota or scheduling issues, which concerned the members. It was discussed how a communications piece to Junior Doctors and Consultants would be beneficial to resolving this issue. The Committee were additionally informed that the advert for the replacement GOSW post will be going live shortly.

ASSURE

Medical Vacancies

The vacancies for medical staff have decreased from 8.3% in July 2021 to 6.9% in month which is highly positive. The Resourcing team are thinking creatively about how the hard to fill posts can be further advertised.

Mandatory Training

Mandatory Training compliance has increased in month to 88.8% from 87.9% in July 2021. Compliance in this area regularly exceeds the current planned target and the Committee were strongly assured.

Time to Hire

Despite time to hire increasing in days in month, the Committee were assured with strong rationale as to the reasons why: the medical changeover in August 2021 caused delays, and additionally there were six new starters that were Band 8a and above who had 3-month notice periods, which increased the time to hire in month.

Band 5 Nurse Vacancies

The trajectory is that the Trust will fill all Band 5 inpatient nursing vacancies by November 2021.

Freedom to Speak Up Annual Report

The Freedom to Speak Up Annual Report highlighted some new recommendations from the National Guardian's Office which the Trust must adhere to. There was discussion about the consistent theme of bullying and harassment and how the Trust will resolve this.

Freedom to Speak Up MIAAA Report

The report identified the Freedom to Speak Up process was highly assuring, which was well received and congratulated by the Committee.

New Risk identified at the meeting

None.

Review of the Risk Register

(Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 OCTOBER 2021
Agenda Item	SO007/21	FOI Exempt	NO
Report Title	Guardian of Safe Working Quarterly Trust Report (1 April to 30 June 2021)		
Executive Lead	Dr Kate Clarke, Medical Director		
Lead Officer	Dr Sharryn Gardner, Guardian of Safe Working		
Action Required	<input checked="" type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input type="checkbox"/> To Receive	
Purpose			
To update on issues related to Guardian of Safe Working			
Executive Summary			
Key Messages of this Report & Recommendations:			
<ol style="list-style-type: none"> 1) Trainees felt cared for by the Trust during the initial Covid pandemic with good PPE stock and quality, food provided free on shift, parking also free. 2) Trainees struggled dropping a rotation due to the first wave and felt that they missed opportunities for training. This Trust managed any redeployments (which were minimal) better than most other local Trusts. 3) Sporadic specific issues in Exception Reporting. Issues mainly around scheduling for on calls resulting in significant daytime gaps. 4) Exception Report system for payment is not working reducing likelihood of reports. 5) Delays in meetings or absence of meetings continues to be an issue. 			
Recommendation			
The Board / Committee is asked to			
Previously Considered By:			
<input type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee		<input type="checkbox"/> Quality & Safety Committee <input checked="" type="checkbox"/> Workforce Committee <input type="checkbox"/> Audit Committee	
Strategic Objectives			
<input type="checkbox"/> SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services			
<input checked="" type="checkbox"/> SO2 Deliver services that meet NHS constitutional and regulatory standards			
<input checked="" type="checkbox"/> SO3 Efficiently and productively provide care within agreed financial limits			
<input type="checkbox"/> SO4 Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated			
<input type="checkbox"/> SO5 Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values			

<input type="checkbox"/> 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 Sharryn Gardner, Guardian of Safe Working	Dr Sharryn Gardner, Guardian of Safe Working

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT

1 April – 30 June 2021

INTRODUCTION

As Guardian of Safe Working, I am responsible for collating information with regard to safe working for trainee doctors. This information is produced from Hours, Pattern and Service

Support Exception Reports generated by trainees Education Exception Reports are monitored by Director of Medical Education and she will report on these to Board.

1. EXCEPTION REPORT OVERVIEW (30th June 2021)

Covid-19 and its ramifications continue to affect day to day hospital work and so affect trainees.

Covid-19 levels of Delta in the community remain high while hospitalisations remain lower than pre-vaccine. Most trainees appear to have obtained the vaccine. Services have been busier than usual, and modelling suggests that the winter may be the worst the NHS has seen. The summer since June has remained exceptionally busy (mostly non-Covid-19) before schools returning and normal winter pressures start.

Elective services had been restarting.

Exception Report completion rates continue to be very sporadic, and reports continue to come in bursts from one individual at a time, six of the eight this time from one individual so not very representative of the whole group.

Payments and some flexibility from HR about swapping payment or TOIL have been greatly appreciated and not (yet) translated into encouraging further Exception Reports.

Most Exception reports have been closed with TOIL in this quarter (again recognising that six of the eight were from one individual closely spaced in submission dates.)

As often, the biggest issues are not recorded in any Exception Reports. Trainees do not see the value in using reports to highlight rota issues or scheduling issues and see them (mainly) as a contractual recompense for staying late.

This reticence may be around the time and effort required to complete an Exception Report and the delay in any potential action which may (or may not) help the next rotation in that post.

Scheduling to cover the on-call rota continues to leave daytime gaps which can be concentrated within one or two teams. When combined with days off due to nights / days off pre- or post-weekend these gaps can be the majority of a ward team.

Trainees were offered the chance to meet with the previous Medical Director around this issue and did not take up the offer. There is a view amongst trainees that this issue is so obvious and in need of remedy that they expect our staffing services to address it alone. The fact remains

that the issues need resolution, and we will need to bring representatives together to look at these issues in the round. We cannot let it continue as it is.

Trainee and supervisor meetings continue to be a black spot with meetings often held well after the 7-day requirement (or more often not at all). Many historical exceptions are closed with payment as the meetings just didn't happen.

While not a specific issue some issues around Consultant approaches to Exception Reports were highlighted by the trainees and me to the new EMD at the most recent Trainee Doctor Forum. Consultants apparently actively discouraging ERs (EMD will discuss at next Consultants Meeting to support the positive process and potential resource implications)

Some Consultants expecting new trainees to be up to speed immediately in new role (balance between being new and performing at expected level for a new trainee).

Some Consultant Supervisors unwilling to sanction Reports from posts in other specialties as no direct knowledge (better to ask their home specialty than just cancel the ER).

1.1. MEDICINE

Workload across the organisation remains high. All eight Exceptions Reports this quarter were from medicine one about Service Support (short on the day staffing) and seven for extra hours worked.

1.2. SURGERY

No Exception Reports this quarter.

2. PAYMENT AND FINES

There have been no GoSW fines levied in either of the last three quarters. There was one potential episode picked up by a trainee that should have flagged and was resolved before the day of the issue. It remains unclear why this was not picked up by the Allocate software.

3. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rota's are 2106 compliant. There were no Work schedule reviews during this period.

A number of rotas continue not to be compliant with the maximum 1:3 weekends and this should have been in place across the board by August 2020. The GoSW has pushed several times in contact with CDs in these areas to look at planning for this.

This is now a serious issue - the BMA suggested that we put Locum slots into these rotas so that trainees will get paid extra or the additional weekends. We don't and can't pressure trainees to take up locus so this would not be a solution. Staffing changes have been sidelined because of Covid-19 to support this. It must however be resolved as soon as possible.

4. DOCTORS NOT ON THE NEW CONTRACT

All trainees are on the 2016 contract.

No concerns about safe working from non-trainee doctors have been escalated to the GoSW.

5. VACANCIES (as of 17 September 2021)

SOHT continue to actively recruit and therefore vacancy rates are changing frequently. Medical staffing has been much more on top of issues and resolved issues quickly recently. Their assessment of vacancies and that of Finance are not quite in sync (as per most recent Trainee Doctor's Forum) and work is underway to sync these. For that reason, there isn't at this moment a definite vacancy list to submit.

6. TRAINEE CONCERNS

- a) Attendance at the TDF continues to be a feast or a famine despite the option of connecting via Teams remotely.
- b) A further issue is a degree of lack of ownership from the trainees where trainees present agree to gauge opinions or get additional ideas / information and then do not attend the next meeting or provide feedback such that we effectively tread water on a number of issues.
- c) The trainees are mostly not presenting with significant concerns. Most Exception reports are about staying late for 30 mins - 2hrs. I don't believe that this means that there are no active issues.
- d) Scheduling around on calls is leaving gaps in daytime cover in both medical and surgical wards. This continues to be the biggest issue and we must come up with a way to explore this further.
- e) Trainees are due to have Self-Development Time structured into rotas. Even more importantly, we should ensure that it is actually working and that they do get to use it. It equates to one hour per week on average for F1s and two hours per week for F2s. Just like teaching it seems to work better when allocated in small blocks away from the ward. Specialties are experimenting with this currently and there remains work to do for it to work effectively.
- f) Trainees report delayed responses to annual leave requests and cancellation of expected leave at very short notice. We expect six weeks' notice and late notice means that a further six weeks' notice makes taking any leave very difficult. Some rotas, while not having fixed leave built-in, actually still significantly limit opportunities for leave. One has been reworked and much improved and there may be others similarly affected.

7. FACILITIES

Facilities funding of over £60,000 has been made available for the Trust's Trainee doctors to improve rest and related facilities. It has been used to upgrade the mess in ODGH (indirectly funded) and to improve the Senior Trainee room at SDGH. There remains an outstanding proposal to change the kitchen/bar/toilets area in the CEC to a bigger sleep area with non-gendered bathrooms. Estate's capacity to do this remains an issue and has been pushed again this week. This will need executive support to push now as it has gone on so long and the money needs to be spent (more may follow if spent).

8. ADDITIONAL GOSW CONCERNS

In terms of management priorities

- 1) 2 rotas remain non-compliant. Both with the requirement for trainees to do a maximum of 1 in 3 weekends. They are in Urology (Tier 2) and Paediatric A&E. In urology the trainees and department are reported to favour the current pattern and I am contacting this cohort to see if they agree with this. In Paediatric A&E the issue is a combination of required significant financial investment and of fears of difficulty recruitment. The BMA are clear that these 2 situations cannot continue being non-compliant with the rota. Within the region the only other rota which remained non-compliant has been improved (another paediatric A&E rota). We are now the only Trust with non-compliant rotas.
- 2) Issues around daytime impact from on call rotas needs a bigger piece of work around it.
- 3) Consultants don't understand and aren't engaged in this process, and this will need a big push. We have good support from Cathy Moss and Andrea Padgeon.
- 4) Current Guardian of Safe Working resigned and completed notice period. Awaiting advert / confirmation of replacement.

Dr Sharryn Gardner
Guardian of Safe Working
17 September 2021

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 October 2021
Agenda Item	SO007/21	FOI Exempt	YES
Report Title	FREEDOM TO SPEAK UP QUARTER 1 REPORT		
Executive Lead	Bridget Lees, Executive Director of Nursing Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom to Speak Up (FTSU) Guardian		
Action Required	<input checked="" type="checkbox"/> To Approve <input checked="" type="checkbox"/> To Assure	<input type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
The Committee is asked to receive this report as assurance that staff members feel able to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place for staff to do this safely and confidently, knowing that appropriate action will be taken.			
Executive Summary			
<p>This report identifies the number of concerns raised through the Freedom to Speak Up service (FTSU) during Quarter 1 of 2021 (1 April – 30 June). Over the quarter, 17 concerns have been raised through FTSU. To help with the overview, some statistics are included from previous quarters. The report also provides assurance of the significant improvement journey that <i>speaking up</i> has made since the National Guardian's Office case review in summer 2017. During the first quarter the themes of concerns raised have included:</p> <ul style="list-style-type: none"> • Staff and patient safety during Covid-19 • Treatment of staff by managers • Patient experience • Redeployment • Racism (Staff to staff) • Staff moral • Future of vulnerable service • Behaviours and relationships <p>In April 2021 the NGO published recommendations about the use of Champions. This report contains an overview of how this affects the Trust. The Committee is asked to approve these recommendations.</p>			
Recommendations			
The Committee is asked to receive this report as assurance and approve it for submission to Trust Board.			
Previously Considered By:			
<input type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee		<input type="checkbox"/> Quality & Safety Committee <input checked="" type="checkbox"/> Workforce Committee <input type="checkbox"/> Audit Committee	
Strategic Objectives			
<input checked="" type="checkbox"/> SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services			
<input checked="" type="checkbox"/> SO2 Deliver services that meet NHS constitutional and regulatory standards			

<input type="checkbox"/> 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	
<input type="checkbox"/> SO6 Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	Presented By:
Martin Abrams, Freedom to Speak Up (FTSU) Guardian	Martin Abrams, Freedom to Speak Up (FTSU) Guardian

Introduction

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

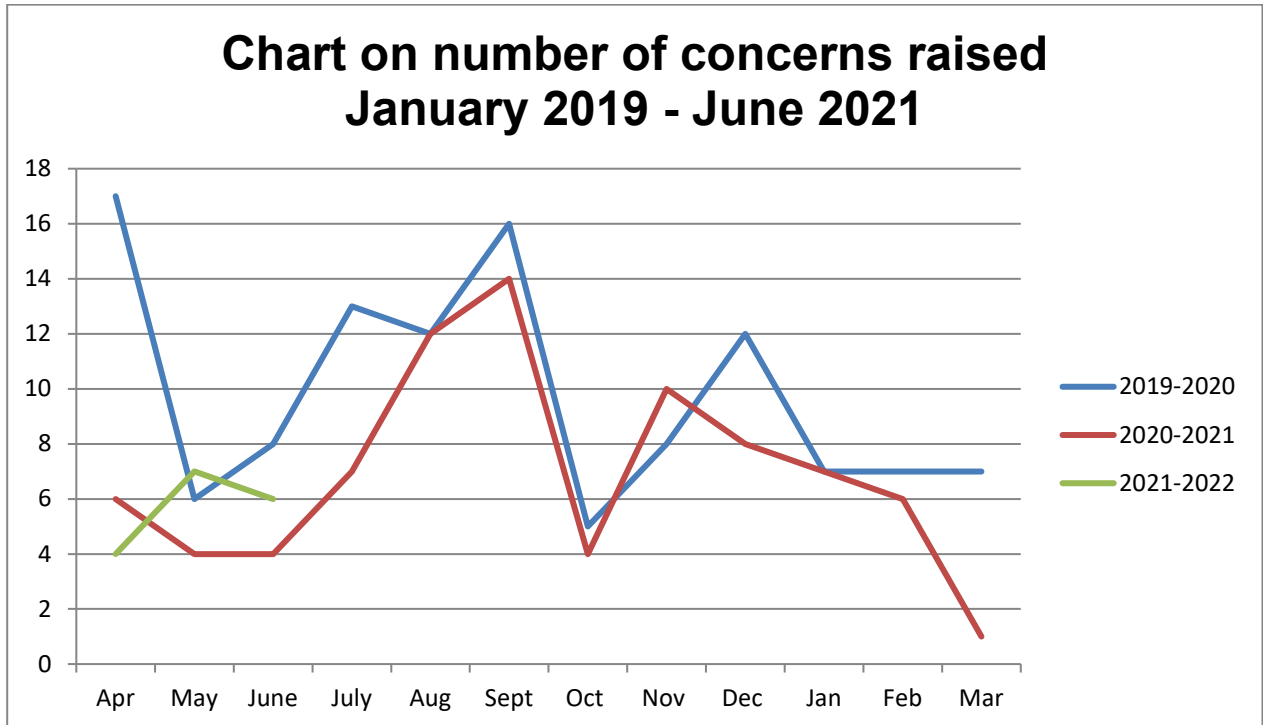
1. Report on Submission to National Guardian’s Office

Quarter 1 1 April – 30 June 2021

Date to be submitted to NGO: 13 July 2021

Date National Data to be published: To Be Confirmed

Number of Concerns Raised 17 (April 4, May 7, June 6)
 16 of these were directly with the Freedom to Speak Up Guardian (FTSUG) and one was raised through FTSU Champions. When concerns are raised directly with FTSU champions, the FTSUG always gives support and advice, often meeting those who raised the concern, and sometimes being used in a consultative role.



2. Themes of Concerns

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

- Staff and patient safety during Covid
- Treatment of staff by managers
- Patient experience
- Redeployment
- Racism (Staff to staff)
- Staff moral
- Future of vulnerable service
- Behaviours and relationships

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

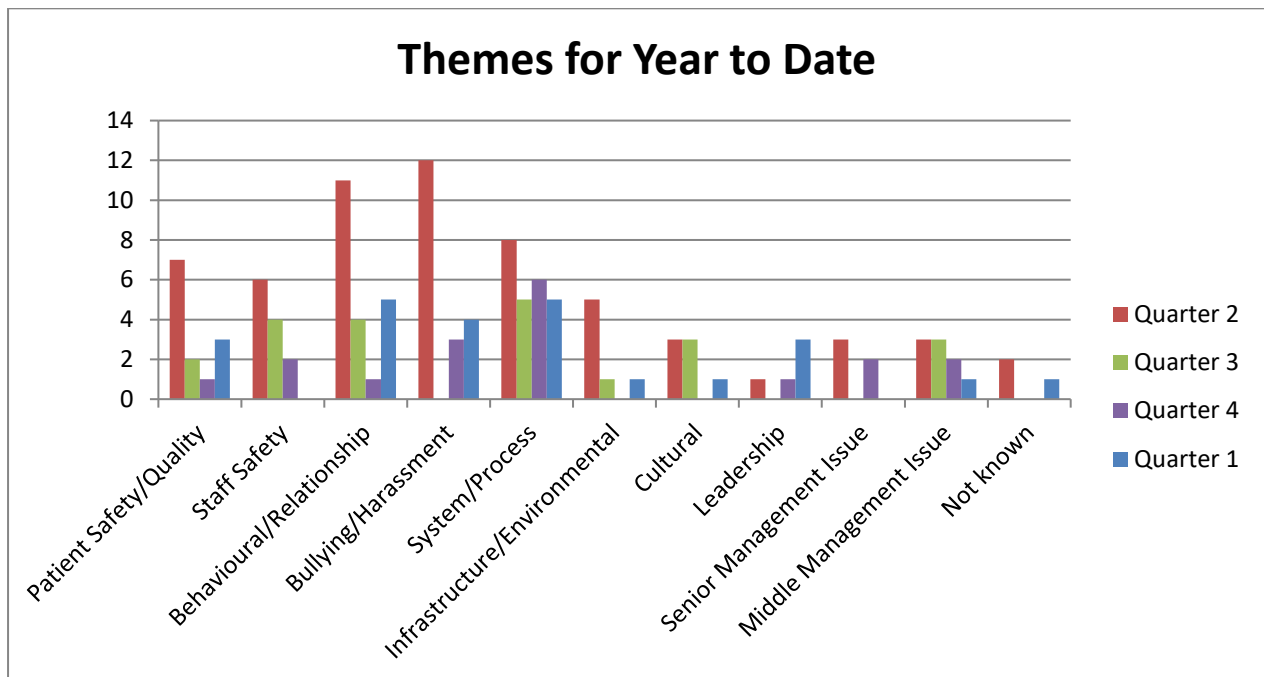
(Please note the themes in the %table and the graph are the categories required by the National Guardian's Office for submission)

Theme	% this Quarter
Patient Safety / Quality	12.5%
Behavioural / Relationship	20.83%
System / Process	20.83%
Cultural	4.17%
Infrastructure / Environmental	4.17%
Bullying/Harassment	16.67%
Leadership	12.5%
Middle Management issue	4.17%
Not Known	4.17%

Graph of Themes for Year to Date

Below is a graph expressing the themes of concerns raised over the last four quarters:

(Please note the quarter 1 is the most recent (April – June 2021, with previous quarters relating to 2020-2021)



3. Anonymous Concerns

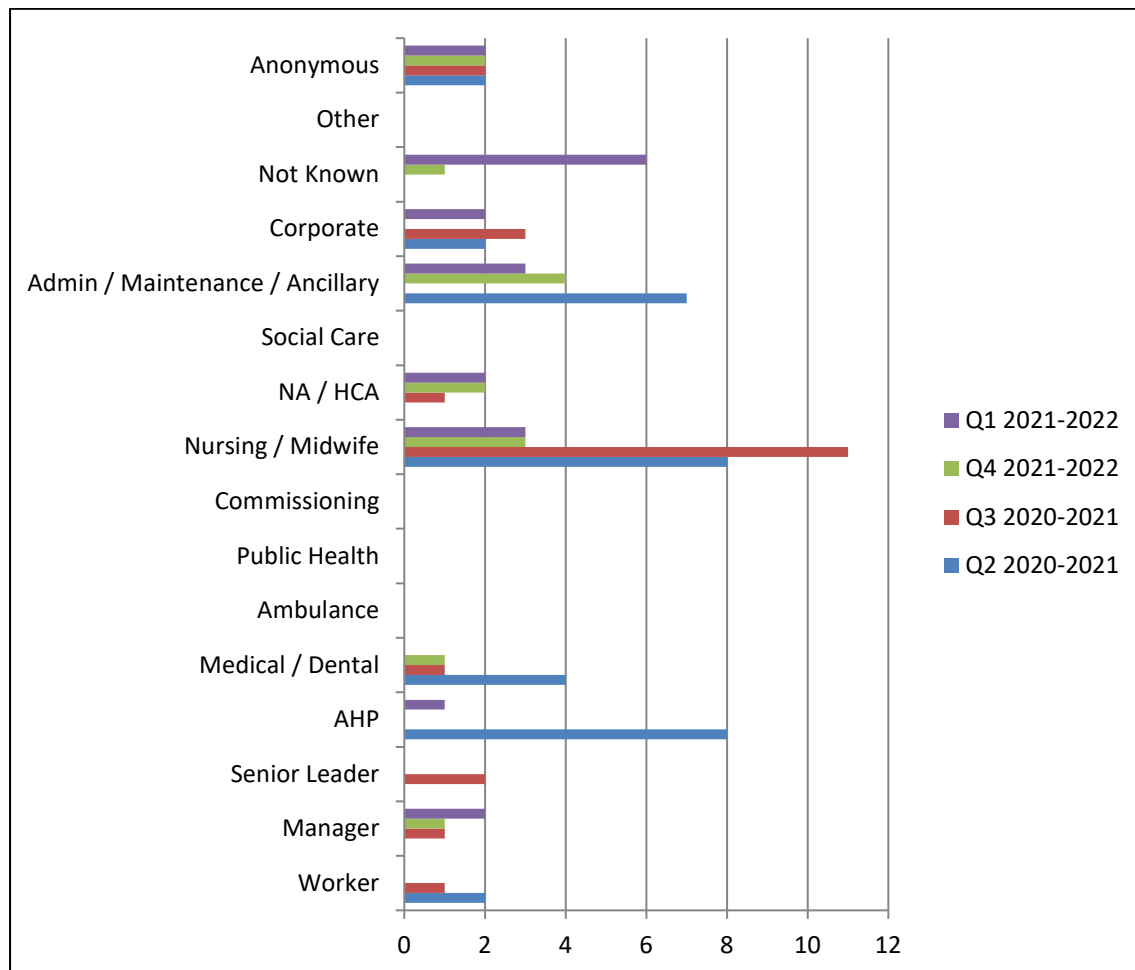
During Quarter 1, there were two anonymous concerns. This is where the person raising the concern cannot be contacted as there are no contact details, e.g., anonymous letter / phone call. There were also four concerns where the person does not want their name associated with the concern as they were worried about repercussions.

4. Staff Groups Raising Concerns

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

Staff Group	% this Quarter
AHP	5.88%
Medical and Dental	0.00%
Nursing / Midwives	17.65%
HCA	11.77%
Admin	17.65%
Corporate	11.77%
Not known	35.29%
Other	0.00%
Anonymous	11.77%

5. Staff Groups Raising Concerns Over the Year



6. Situations where detriment was expressed because of speaking up

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

7. Feedback Post Raising Concerns

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

- Would they use the FTSUG again to raise a concern?
- Would they like to offer further comments about the service or the process?

During this quarter feedback was received from 16 people who have raised concerns with the FTSU service. Eight of these were verbal and eight via e-mail. The higher number than usual is due to us catching up on, and closing concerns following the Covid-19 pressures of the last sixteen months. Fifteen of the sixteen responses were positive about the service, but some negativity expressed about outcomes and communication. Examples are as follows:

- *I would definitely speak up in the future if I ever felt the need. I feel that going to speak with ***** made some difference and slight improvements. I didn't realise that mediation would be so stressful, I thought the mediator would at least do some of the talking to the other party, for example explain initially what the problems were and the possible outcome. Sort of an introduction just to ease the nerves, but **** said that wasn't possible and I would have to do all of the talking. Sorry too stressful for me. Not good for my anxiety. That's all I can think of regarding improvements, I am sure that most people in my situation, (feeling like they are being bullied by a manager) would feel intimidated by mediation in this way.*
- *Thanks for your email. Funny enough we were discussing the service this morning as the possible need to access it again. Things are far from great at the moment, but we have a meeting with the management team next week, so, fingers crossed. I think the service is great, but the management are very slow to rectify problems if they do at all.*
- *No I would not speak up again as nothing was done or has changed*
- *Yes, I would have no hesitation in speaking up again as the process followed by you was very good and I was put at ease throughout the process.*
- *Although I feel I have been treated well by yourselves and had continuous good feedback throughout I do feel that the final conclusion was handled or communicated well by senior staff in the Trust.*
- *Yes, I am glad I spoke up I feel there is some bullying and certain staff get away with stuff. I will keep speaking up as I feel strong.*
- *I am happy for you to close our concern. Thank you for your time and expertise in this matter, it was greatly appreciated. Thank you*
- *In response to your questions, undoubtedly, I would not hesitate to use the service again. I found the support invaluable, I felt listened to in a safe and secure fashion. I really don't have anything that I think would improve the service but would like to take the opportunity to say again thank you for all your support. Keep up the good work. Thank you*
- *I was certainly supported to speak up - although there is now very slow process to evoke any change. I was made to feel comfortable voicing my concerns and that what I had to say mattered*
- *Given your experience, would you speak up again?*
- *"Yes"*
- *Any other comments you would like to make or suggestions for improving the service offered?*
- *No. great support from the guardians*

8. Changes as a Result of Speaking Up

The question is often asked *What things have changed as a result of people speaking up?* Each quarter we try to offer a short overview of some of the changes.

One of the recurring themes that continues to be apparent through concerns raised is that of the behaviours being displayed by a small number of staff which are not in keeping with the SCOPE values of the Trust.

The response to this is ongoing and I understand a trust wide piece of work is beginning on this soon.

Recent conversations have also highlighted FTSU as providing:

- A member of staff was placed on restricted duties following a concern raised in relation to patient safety
- Mediation and coaching within departments / services
- Involvement in future planning about a vulnerable service
- Support and coaching given on recruitment and selection process
- A vacant post (for which recruitment was on hold) was recruited to
- Signage changed to reflect changes in process
- Following the closure of a ward learning points have been discussed about process and communication with senior leaders.

9. How Concerns are Managed

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

10. Training and Development for Guardians

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

11. Update on Freedom to Speak Up, Raising Concerns Policy (Corp 69)

The updated policy has been approved by the Trust board and relevant committees. It is now awaiting final approval by PRG.

12. Concerns Taken Directly to CQC

During Quarter 1, one concern was taken directly to CQC.

13. Freedom to Speak Up Champions – new guidance from the NGO

In April the National Guardian's Office provided new guidance on FTSU Champions/Ambassadors (See Appendix A). This has implication for organisations who use Champions / Ambassadors, and a response has been offered to the NGO by the regional meeting. The NGO offers the following principles for the role of Champions, whose role is seen as:

- Awareness raising – being visible and accessible
- Signposting and support – understanding when to sign post, when to escalate and when to seek support
- Feedback – understanding the importance of feedback
- Learning – mechanisms to be in place to ensure that issues/themes are captured and communicated sensitively for wider learning

Below is a table summarising the recommendations from the NGO with some commentary and local recommendations for approval.

Recommendation from NGO	Impact on Local / SOH practice	Local Recommendation
Distinguish between the role of guardian and champion so that only FTSUG's handle Concerns	Generally, this distinction is made, though a small number of concerns have been raised directly with champions. However, when the FTSUG is on leave or absent from the trust Champions are offered as the first point of contact.	A deputy Freedom to Speak Up Guardian be appointed to cover any absence of the FTSUG
Do not use the term 'Advocate'	We have always used the title "Champion"	No Change
Champions are given ring fenced time to do the role	This has not happened.	See below and recommendations on appointment of champions. Specifically, time be discussed with FTSUG and manager / CBU manager when champions appointed.
Champions are appointed in a fair and open way and barriers to appointment are identified and addressed	Nominations for champions has always been open to all. Approval has been given by the DON in consultation with the FTSUG.	We continue to receive applications in a fair and open way. However, applications to be made to the FTSUG and interview to include: <ul style="list-style-type: none"> • FTSUG • Line manager or directorate Manager • Senior member of FTSU management team
Encourage applicants from groups who face barriers to speaking up		Work with equalities lead and staff networks to identify appropriate champions
Champions undertake NGO/Health Education England Speak up, Listen Up training	Some of this already done as part of mandatory training	Ensure all champions receive this training
Champions are provided with regular suitable support	Pre covid regular meetings and conversations were set up. More recently occasional meetings have been arranged	Set up regular meetings for support
The use and effectiveness of local FTSU networks are regularly reviewed		To be included as part of the annual policy review

The above table is offered for local approval, and if approved the FTSU policy will be amended accordingly.

The full report is here:

[Developing Freedom to Speak Up Champion and Ambassador Networks \(nationalguardian.org.uk\)](https://nationalguardian.org.uk)

14. MIAA Audit

There is to be an independent audit of the concerns raised with Freedom to Speak Up for the last year (2020 – 2021). This is taking place in early August 2021.

15. The National Picture

The NHS national guardian for Freedom to Speak Up, Dr Henrietta Hughes, has announced she is stepping down after five years in the role. Dr Hughes said: “I would like to pay tribute to the incredible workers in the NHS who have faced the most challenging time in our history. I would like personally to thank the people who have brought 50,000 cases to Freedom to Speak Up Guardians to keep their patients and colleagues safe and well. “It takes courage to speak up and also courage to listen up and follow up. It has been the most tremendous privilege to work with Freedom to Speak Up Guardians and my team at the National Guardian’s Office who display this courage on a daily basis. The impact of their work is outstanding and has moved the dial on the speaking up culture in the NHS.”

16. Strategic Framework

At the time of writing the NGO has just published its Strategic Framework. The press release is below and the link to the full report is:

[NGO-Strategic-Framework-2021.pdf \(nationalguardian.org.uk\)](https://nationalguardian.org.uk/NGO-Strategic-Framework-2021.pdf)

Press release 22nd July 2021

National Guardian’s Office publishes Strategic Framework for Freedom to Speak Up The Strategic Framework, published today (22nd July), outlines the National Guardian’s Office priorities for Freedom to Speak Up for the healthcare sector.

In the five years since the Freedom to Speak Up Review, much has been achieved. There is now a network of over 700 Freedom to Speak Up Guardians supporting workers in nearly 500 organisations. The strategic direction of the National Guardian’s Office is to build upon the improvements that Freedom to Speak Up has already made, ensuring that speaking up arrangements work consistently well. The freedom to speak up should be available to everyone in the healthcare system, irrespective of where they work.

Over the past five years, the work of the National Guardian’s Office has shown that the promoters and barriers of speaking up are universal. Universal principles for creating a speak up, listen up, follow up culture – and implementing the Freedom to Speak Up Guardian role – will promote consistency and support the development of a more integrated healthcare system. This Strategic Framework also sets out the intention of the National Guardian’s Office to obtain greater assurance about speaking up cultures and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented. Russell Parkinson, Head of Office and Strategy for the National Guardian’s Office, said:

“This framework enables the National Guardian’s Office to build on the achievements of Freedom to Speak Up to date and to respond to wider changes in the healthcare landscape. The 50,000+ cases that have been brought to Freedom to Speak Up Guardians have offered 50,000+ opportunities for

learning and improvement. But despite this, the pandemic has highlighted how much more needs to be done.

“The most immediate concern of the National Guardian’s Office is ensuring that speaking up works well now so that our healthcare workforce feels empowered and listened to. Making speaking up business as usual will enhance the working life of the healthcare workforce and improve the quality and safety of care.

“This Strategic Framework will give the new National Guardian a framework to build upon, shape and lead.”

This Strategic Framework has been developed with valuable contributions from colleagues in national bodies, leaders and workers’ representatives – including from outside the healthcare sector – and Freedom to Speak Up Guardians. We are grateful for their input and guidance.

17 Annual Data Report

At the time of writing the NGO has not published its 2020/21 full Annual Data Report, however the following extract has been offered to Guardians:

“Next week, we will publish the 2020/21 Annual Data Report. Guardians have an exclusive opportunity to view the Data Report on our website before its official publication date.

Over 20,000 cases were raised to Freedom to Speak Up Guardians throughout 2020-21 – a 26 percentage point increase from the previous year. Guardians have now handled over 50,000 cases since the NGO first started collecting data in 2017.

The percentage of cases involving an element of patient safety or quality of care has decreased (down from 23% to 18%) while cases involving elements of bullying and harassment have also dropped – from 35% in 2019-20 to 30.1% in 2020-21.

Whilst the proportion of cases which indicated detrimental treatment for speaking up has slightly decreased (3.4% in 2019/20 to 3.1% in 2020/21), over the course of the year the percentage of cases involving detriment increased from 2.7% in Q1 (April to June 2020) to 3.5% in Q4 (January to March 2021).

Similarly, the decrease in the percentage of cases which are raised anonymously has slowed, with 11.7% being raised anonymously. With an increased number of cases, that means the actual numbers have increased overall. This remains a concern, as workers speaking up anonymously may be an indicator of fear and mistrust in the system.

In this time of crisis, Freedom to Speak Up Guardians made sure that workers knew they were still listening and still there to support them. Thank you for continuing your great work throughout the pandemic.”

Freedom to Speak Up Review Assignment Report 2021/22 (Final)

Southport and Ormskirk Hospitals NHS Trust

Report Ref: 105SOHT_2122_017

Date of Issue: 21st September 2021

Contents

- 1 Executive Summary
- 2 Engagement Objectives and Scope
- 3 Detailed Findings and Recommendations

Appendix A: Assurance Definitions and Risk Classifications

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Reports prepared by MIAA are prepared for your sole use and no responsibility is taken by MIAA or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards.

Key Dates

Report Stage	Date
Discussion Document Issued	August 2021
Discussion Meeting	August 2021
Final Draft Report Issued	August 2021
Client Approval Received	August 2021
Final Report Issued	September 2021

Report Distribution

Name	Title
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Martin Abrams	Freedom to Speak Up Guardian
John McLuckie	Director of Finance
Pauline Gibson	Non-Executive

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Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review. This report has been prepared as commissioned by the organisation and is for your sole use. If you have any queries regarding this review, please contact the Audit Manager. To discuss any other issues then please contact the Director. MIAA would be grateful if you could complete a short survey using the link below to provide us with valuable feedback to support us in continuing to provide the best service to you. https://www.surveymonkey.com/r/MIAA_Client_Feedback_Survey

1 Executive Summary

1.1 Objective

The overall objective of the audit was to select a random sample of Freedom to Speak Up cases and for each the following sub-objectives were to be confirmed:

- An independent investigator was appointed where required (per policy)
- Confirmation of observation of anonymity and importance of protection (per policy)
- Ensured that rights to access information had been adhered to.

1.2 Opinion

High Assurance	There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed.
-----------------------	---

1.3 Key Findings

Overall, there was a strong system of internal controls in relation to the Freedom to Speak Up process. Sample testing on 10 cases demonstrated that confidentiality was maintained for those who wished to remain anonymous and that all case files were stored in a private folder with restricted access.

The following provides a detailed account of the key themes.

Sub Objective	Key Themes
An independent investigator has been appointed where required (per policy)	<p>Areas of good practice:</p> <ul style="list-style-type: none"> • From the sample of 10 cases selected, 3 cases required an independent investigator to be appointed. 2 of the cases had an investigator appointed and Union representation was in place for the third case.
Confirmation of observation of anonymity and importance of protection (per policy)	<p>Areas of good practice:</p> <ul style="list-style-type: none"> • From the sample of 10 cases, 4 cases were submitted confidentially. Evidence showed all 4 of the cases had been kept confidential. <p>Areas for improvement</p> <ul style="list-style-type: none"> • From the sample of 10 cases, one case did not show clear evidence as to whether the individual raising the concern wanted to remain confidential. From discussions with management, it was identified that if in doubt the case would

Sub Objective	Key Themes
	be treated as confidential. No confidentiality breaches were identified. (Recommendation 1 – Low)
Ensured that rights to access information have been adhered to.	Areas of good practice: <ul style="list-style-type: none"> • Each of the 10 cases in our sample demonstrated that information was only shared with the key personnel who were necessary to rectify the situation or those that were explicitly agreed by the individual raising the concern. • Case files are stored electronically in a folder that is only accessible by the Trust’s Freedom To Speak Up Guardian and Freedom To Speak Up Administrator.

1.4 Recommendation Summary

The table below summarises the prioritisation of recommendations in respect of this review.

Critical	High	Medium	Low	Total
0	0	0	1	1

2 Engagement Objectives and Scope (Terms of Reference)

2.1 Objective

The overall objective of the audit was to select a random sample of Freedom to Speak Up cases and for each the following sub-objectives were to be confirmed:

- An independent investigator was appointed where required (per policy)
- Confirmation of observation of anonymity and importance of protection (per policy)
- Ensured that rights to access information had been adhered to.

2.2 Scope

We reviewed the objectives and risks identified above in respect of Freedom to Speak Up through review and documentation of the system and testing for compliance with the expected controls and best practice.

The limitations to scope were as follows:

- The scope of this review focused on the objectives described above and was limited to the controls in operation at the Trust.

2.3 Approach

The following approach was adopted to enable us to evaluate potential risks, issues with controls and recommend improvements:

- Discussions with key members of staff to ascertain the nature of the systems in operation
- A desktop review of a sample of 10 cases

3 Detailed Findings and Recommendations

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

1. Confidentiality Requested	Risk Rating: Low
Operating effectiveness	
<p>Key Finding – From the sample of 10 cases, one case did not show clear evidence as to whether the individual raising the concern wanted to remain confidential. From discussions with management, it was identified that if in doubt the case would be treated as confidential. No confidentiality breaches were identified.</p>	
<p>Specific Risk – It may not be known if the employee wants to remain confidential and so confidentiality breaches may take place.</p>	
<p>Recommendation – Confirm and explicitly state for each case whether the individual raising the concern has requested confidentiality.</p>	
<p>Management Response – The scenario highlighted is unlikely to be repeated as the guidance from the National Guardian's Office has changed in relation to this kind of concern. Therefore, the system has already changed. The scenario highlighted was a concern raised by a group of staff in relation to their area of work. At a meeting notes were taken and circulated among the staff for agreement. This was recorded as one concern. Verbal assurance was given at the meeting only themes would be passed on, which was the case. The guidance from the NGO is now each person present at such a gathering should have a concern recorded in their name, which on our documentation (pro-formas) would include a written note about confidentiality preferences.</p>	
<p>Responsible Officer – Freedom to Speak Up Guardian</p>	
<p>Implementation Date – Implemented</p>	

Follow-up

A follow-up exercise will be undertaken during the next 12 months to evaluate progress made in respect of issues raised. This will include obtaining documentary evidence to demonstrate that actions agreed as part of this review have been implemented.

Appendix A: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: <ul style="list-style-type: none"> the efficient and effective use of resources the safeguarding of assets the preparation of reliable financial and operational information compliance with laws and regulations.
High	Control weakness that has or could have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: <ul style="list-style-type: none"> has a low impact on the achievement of the key system, function or process objectives; has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	27 SEPTEMBER 2021
Lead:	JEFF COZER

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Fluctuating Wave 3 Covid-19 position with % of beds occupied by Covid-19 patients ranging between 5% and 10%. Modelling suggesting trusts need to plan for levels between 10% and 30% for winter. In regard to service delivery, it was reported to the Committee that the need for staff to self-isolate through the 'ping-demic' coupled with August annual leave was having a significant impact upon staffing levels and service delivery. Impacted the elective restoration position with some high volume activity cancelled.
- Endoscopy capacity is limited by the Trust's ability to only deliver single sex lists which is impacting upon waiting times for cancer.
- The Trust has required £0.5m of support from the Cheshire and Mersey system, in order to achieve breakeven in H1 of 2021-22.

ADVISE

- Theatre utilisation at both sites continues to improve. The 6-4-2 theatre booking system continues to have a positive impact towards improving utilisation rates. Empty theatre slots are currently being filled with P3 and P4 patients who have been waiting over 52 weeks.
- It was reported to the Committee that despite previous good performance in relation to the elective restoration plan, there has been some adverse movement. Elective day cases remain the most challenged as a result of the decision to focus resource upon reducing the number of P2 patients on the waiting list.
- The Committee was advised of the continued pressure Urgent Care is experiencing, with high levels of attendances. This has resulted in performance levels falling below target in some areas, particularly in relation to the 4 hour standard. Fourteen 12 hour breaches were reported in August 2021.
- The refurbishment of wards 7a, 10a, and 10b have been deferred to 2021/22 to reduce the current deficit of beds due to unprecedented demand.
- The fragile service review has now been completed and next steps will commence on the development of an action plan, collaboration assessment and financial assessment.
- The draft winter plan was presented to the Committee for information. A further iteration will be received by FP&I committee in October 2021 which will be updated to reflect the H2 guidance.

ASSURE

- Despite challenges with urgent care performance, corridor care has remained at zero and the Trust remains in the top quartile for ambulance handovers.
- The Trust continues to be below trajectory for 52+ week waiters and reports zero 104+ week waiters.
- As part of the electrical infrastructure work at the Southport site, the two backup generators have now been installed.
- The fire compartmentation and alarm work at the Southport site is progressing.
- The remediation work to the network and Wi-Fi is progressing.

New Risks identified at the meeting:

None

Review of the Risk Register: *No action taken*

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 October 2021
Agenda Item	SO008/21	FOI Exempt	YES / NO
Report Title	DRAFT WINTER PLAN		
Executive Lead	Lesley Neary, Chief Operating Officer		
Lead Officer	Lesley Neary, Chief Operating Officer		
Action Required	<input type="checkbox"/> To Approve <input checked="" type="checkbox"/> To Assure	<input checked="" type="checkbox"/> To Note <input checked="" type="checkbox"/> To Receive	
Purpose			
<p>In the absence of H2 guidance, the purpose of this paper is to:</p> <ul style="list-style-type: none"> Assure the Committee that winter planning will form part of the Trust's H2 planning for 2021/22. Assure the Committee that the Trust has taken an integrated approach to setting out the DRAFT plans for winter 2021/22. Update the Committee regarding the DRAFT internal winter plan for 2021/22 and current winter schemes to address the expected increase in demand. 			
Executive Summary			
<ul style="list-style-type: none"> This paper provides an update on the Trust's internal DRAFT plans for winter 2021/22 in terms of meeting expected increase in demand levels. Winter planning needs to form part of H2 2021/22 planning. Planning guidance for H2 2021/22 due for publication 24 September 2021. Unclear on any additional funding for winter or income for additional activity levels DRAFT Winter Plan 2020/21 but acknowledging that likely we will still have to <ul style="list-style-type: none"> To return to the 2019/20 baselines for elective work Ensure 95% of priority 2 (P2) priority patients are dated in < 28 days Meet cancer standards Eradicate 52 week breaches Deal with increase in Covid-19 admissions Continue to deliver against IPC requirements Look after staff health and well being Key driver for internal winter plan is reduce bed occupancy. Bed occupancy is the key to safe, timely & effective patient flow (85% - 90%). Planning for winter 2021/22 must include plans for managing an increase in Covid-19 demand. G&A Bed occupancy at SDGH (20/09/21) is currently at 98% with 8% of beds occupied by Covid-19 positive patients. Planning for four scenarios for winter – 10%, 15%, 20% and 30% Covid-19 patients in bed base. Plan has been developed by CBU's (triumvirates) A number of schemes for winter 2021/22 have been identified to support flow and reduce bed occupancy. 			

Priority	Indicative Costs (£000)	Comments
CRITICAL	1,431	Includes £209k in run rate
HIGH	886	Additional expenditure
MEDIUM	554	Includes £70k in run rate Plus additional £1m Discharge Lounge external capital bid
TOTAL	2,871	Includes £279 in run rate Plus £1m Discharge Lounge capital bid

Recommendations

The Committee is asked to

- Note that winter planning will form part of the Trust's H2 planning for 2021/22.
- Note that the Trust has taken an integrated approach to setting out the DRAFT plans for winter 2021/22.
- Note the DRAFT internal winter plan for 2021/22 and current winter schemes to address the expected increase in demand.

Previously Considered By:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Finance, Performance & Investment Committee | <input type="checkbox"/> Quality & Safety Committee |
| <input type="checkbox"/> Remuneration & Nominations Committee | <input type="checkbox"/> Workforce Committee |
| <input type="checkbox"/> Charitable Funds Committee | <input type="checkbox"/> 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:

Lesley Neary, Chief Operating Officer

Presented By:

Lesley Neary, Chief Operating Officer



Southport and Ormskirk Hospital
NHS Trust

DRAFT

Internal Winter Plan

October 2021

Lesley Neary – Chief Operating Officer
6 October 2021



Southport and Ormskirk Hospital

NHS Trust

Context

- Winter planning needs to form part of H2 2021/22 planning.
- Planning guidance for H2 2021/22 was due for publication 24th Sep 2021 now expected 30th Sep 2021.
 - Unclear on any additional funding for winter or income for additional activity levels
- DRAFT Winter Plan 2020/21 but acknowledging that likely we will still have to
 - To return to the 19/20 baselines for elective work
 - Ensure 95% of priority 2 (P2) priority patients are dated in < 28 days
 - Meet cancer standards
 - Eradicate 52-week breaches
 - Deal with increase in Covid-19 admissions
 - Continue to deliver against IPC requirements
 - Look after staff health and well being
- Link with wider system plan



What does our data tell us?

- Key driver for internal winter plan is reduce bed occupancy.
- Bed occupancy is the key to safe, timely & effective patient flow (85% - 90%).
- Planning for winter 21/22 must include plans for managing an increase in Covid-19 demand.
- G&A Bed occupancy at SDGH (20/09/21) is currently at 98% with 8% of beds occupied by Covid-19 positive patients.
- Planning for 4 scenarios for winter – 10%, 15%, 20% and 30% Covid-19 patients in bed base.
- Plan has been developed by CBU's (triumvirates)



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Winter Plan 2021/22 - Internal Priorities

- Ensure safe flow and improve patient experience and outcomes
- Mitigate 4 hour and 12 hour DTA breaches
- Reduce total waits in ED (12 hours from presentation)
- Mitigate corridor care
- Ensure clinical discharge efficacy
- Reduce ready for discharge list and reduce average length of stay
- Reduce the number of bed moves per patient
- Ensure resilience of overnight medical teams
- Improve experience of patients presenting with mental health issues in ED
- Improve staff experience and well being
- Improve communications – internal and external



Summary Key Winter Schemes 2021/22

Priority	Indicative Costs (£000)	Comments
CRITICAL	1,431	Includes £209k in run rate
HIGH	886	Additional expenditure
MEDIUM	554	Includes £70k in run rate Plus additional £1m Discharge Lounge external capital bid
TOTAL	2,871	Includes £279 in run rate Plus £1m Discharge Lounge capital bid



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Key Schemes for Winter 2021/22 (CRITICAL)

Scheme	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Winter Ward (11a)	CRITICAL	<ul style="list-style-type: none"> Open 20 beds on ward 11a for medicine with safe staffing levels to support escalation between Nov 21 & Apr 22 	Nov 21	Apr 22	731	<ul style="list-style-type: none"> Increase bed base by 20 beds Reduce bed occupancy Reduce 4/12 hour breaches Reduce 12 hour DTA breaches
Increase in medic cover for Paediatric ED	CRITICAL	<ul style="list-style-type: none"> Paediatric ED Operating 24/7 at ODGH 	Oct 21	Mar 22	446	<ul style="list-style-type: none"> Support influx of Paediatric ED attendances due to RSV surges Support evening and overnight opening hours surges in paediatric activity at ED
Recruitment of a Clinical Discharge Matron	CRITICAL	<ul style="list-style-type: none"> Working alongside the Head of Patient Flow, employ a Band 8a matron focused on supporting timely safe discharge. 	Sept 21	Mar 22	34	<ul style="list-style-type: none"> Reduction in RFD numbers Reduction in avg LOS Reduction in bed occupancy Reduction in adverse discharges Achieve discharge ambition Increase in discharges by 10am and midday Increased utilisation of the discharge lounge
Increase Private Transport Provision	CRITICAL	<ul style="list-style-type: none"> Provision of additional patient transport weekend & evenings to support flow in addition to existing NWAS PTS 	N/A	Mar 22	175	<ul style="list-style-type: none"> Reduced failed discharges due to PTD Reduced Discharge Lounge delays due to capacity Support Covid+ discharges in absence of any other provision Support Bariatric discharges
Staff Well Being	CRITICAL	<ul style="list-style-type: none"> 12 days of Christmas campaign Well being January campaign Feel good February campaign 	Nov 21	Feb 22	45	<ul style="list-style-type: none"> Improve staff morale Reduce staff sickness absence

Key Schemes for Winter 2021/22 (HIGH)

Scheme	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Enhanced Surgical Assessment Unit (SAU)	HIGH	<ul style="list-style-type: none"> Consider expansion of SAU and increase pathways to SAU to support flow & ensure appropriate surgical patients are not waiting in ED for reviews/tests (Potential W1) 	Oct 21	Mar 22	443	<ul style="list-style-type: none"> Reduce 4/12 hour breaches Reduce 12 hour DTA breaches Improve patient experience & outcomes
Enhanced surgical cover overnight	HIGH	<ul style="list-style-type: none"> Extend registrar cover on site from 9pm until midnight. 	Oct 21	Mar 22	35	<ul style="list-style-type: none"> Provides additional senior surgical cover to respond to increased acuity/ admissions Provides supervision for F1 doctor on wards Reduces delay in review overnight Reduces risk of harm due to delayed senior review Ensure availability of senior doctor for ED and support admission avoidance.
Enhance surgical cover at weekends	HIGH	<ul style="list-style-type: none"> Additional FY2 to support surgery and T&O at weekends 	Oct 21	Mar 22	31	<ul style="list-style-type: none"> Provides additional surgical cover to respond to increased acuity/ admissions Provides supervision for F1 doctor on wards Reduces delay in review Reduces risk of harm due to delayed senior review Provides additional support to ensure all ward jobs are completed to enable timely discharge of patients at weekends
Enhance Surgical Flow coordinator	HIGH	<ul style="list-style-type: none"> Additional 1WTE band 5 Surgical Flow coordinator to support surgical flow 	Oct 21	Mar 22	17	<ul style="list-style-type: none"> Achieve discharge ambition Increase in discharges by 10am and midday Increased utilization of the discharge lounge Reduction in >12 hours LOS in ED Reduction in 4 and 12 hour breaches Reduction in cancellations of elective activity due to no bed. Supported flow to ODGH



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Key Schemes for Winter 2021/22 (HIGH)

Scheme	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Enhanced therapy at ward level	HIGH	<ul style="list-style-type: none">Additional Physio and OT on acute and winter wards	Oct 21	Mar 22	100	<ul style="list-style-type: none">Supports flow due to heightened admission profilesEnsures discharges are not delayed to incomplete TADsSupports reduction in LOS
Enhanced Medical Cover Evening & Overnight	HIGH	<ul style="list-style-type: none">Additional senior doctor in medicine overnight	Oct 21	Mar 22	160	<ul style="list-style-type: none">Provides additional senior (ST/SAS) medical cover evening and overnight to respond to increased acuity/admissionsProvides supervision for F1 doctor on wards overnightReduces delay in review overnightReduces risk of harm due to delayed medical review
Increased Mental Health Support in ED	HIGH	<ul style="list-style-type: none">Response and review within 1 hourEscalation and pathway review & operationalNo delays in assessment for T4 beds for all CAMHS patients	Dec 21	Feb 22	100	<ul style="list-style-type: none">Reduce 4/12 hour breachesReduce 12 hour DTA breachesImprove patient experience & outcomes

Key Schemes for Winter 2021/22 (MEDIUM)

	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Transfer Team Twilights	MEDIUM	<ul style="list-style-type: none"> Nursing and HCA team to support transfer from ED to AMU and AMU to ward 	Oct 21	Mar 21	70	<ul style="list-style-type: none"> Reduces impact of nurse staffing on wards Supports flow from ED to AMU and AMU to ward Supports maintaining safe staffing at ward level
Discharge Lounge	MEDIUM	<ul style="list-style-type: none"> Relocate Discharge Lounge to new Portacabin near main Entrance 	TBC	TBC	£1m Capital Bid submitted	<ul style="list-style-type: none"> Uninterrupted discharge lounge facility with increased capacity over the SALUS Centre and no risk being bedded overnight (Ward 1) Supports ease of flow from wards and ED for patients no longer requiring hospital treatment Located at the main entrance ensures ease of access for PTS, families and carers
Frailty Assessment Unit	MEDIUM	<ul style="list-style-type: none"> 4 Bedded Frailty Assessment Unit in SALUS Centre Codependency with discharge lounge above 	Oct 21	Mar 22	Nil – within existing	<ul style="list-style-type: none"> Ability to deliver Frailty Assessment outside of ED footprint without requiring a beds reduction Mitigate unnecessary admission for older people Reduce risk of harms associated with admission to hospital for older people
Extended ACU Offer	MEDIUM	<ul style="list-style-type: none"> Operate Ambulatory Medical Care Unit extended hours 	Dec 21	Mar 22	448	<ul style="list-style-type: none"> Increase number of medical assessment patients eg GP attends from ED to ambulatory medical assessment Reduce midday occupancy in ED Improve ED 4 Hour performance Reduce > LOS 12 Hours in ED Increase <LOS 24 hours in Medicine Improve Community inreach for medicine
Recruitment of 2 x Non Clinical Patient Flow Coordinators	MEDIUM	<ul style="list-style-type: none"> Recruitment of 2 x non-clinical patient flow coordinators to support flow across the hospital, by more timely reporting, capturing of actions, ensure transport booked for discharges and support reporting 	Sep 21	Apr 22	36	<ul style="list-style-type: none"> Reduction in Occupancy at SDGH Site Reduce 12 Hour Breaches Reduce 4 Hour Breaches Improve discharge numbers Improve the percentage of potential discharges to definite



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Next Steps

- Selection of winter schemes based upon H2 guidance and potential funding pot.
- Further quantification based on H2 guidance and requirements and further clarification on likely Covid-19 scenarios.
- Further work with wider system winter plans.
- Development of relevant operational action plans for approved each winter scheme
- Approval at FP&I committee in October 21 and S&O Committee November 21
- Socialise winter plan

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 October 2021
Agenda Item	SO008/21	FOI Exempt	NO
Report Title	MONTH 5 FINANCE REPORT		
Executive Lead	John McLuckie, Director of Finance		
Lead Officer	Andy Large, Deputy Director of Finance		
Action Required	<input type="checkbox"/> To Approve <input type="checkbox"/> To Assure	<input checked="" type="checkbox"/> To Note <input type="checkbox"/> To Receive	
Purpose			
This report provides the Committee with the financial position for August 2021 (month 5), and forecast outturn for H1 of 2021/22			
Executive Summary			
<p>The Trust is required to break-even for the first half of the financial year ('H1'). At month 5, the Trust has delivered services at a £751,000 deficit, following an in-month adverse variance of £496,000. The financial run rate has remained broadly consistent prior to month 5, with pressures being experienced as a result of slippage against H1 CIP plans and continued temporary staffing costs. However planned Elective Recovery Funding (ERF) of £358,000 has reduced to £nil per month following changes to ERF income thresholds effective from July as previously reported. The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed system funding. The Trust requires external cash support during H2 and has taken steps to secure cash for Q3.</p>			
Recommendations			
<p>The Committee is asked to note:</p> <ul style="list-style-type: none"> • Year to date deficit of £751,000 at month 5 • The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed ICS funding • Key actions to address drivers of nursing and medical bank & agency expenditure specifically in the Medicine and Emergency Care CBU • Risks to delivery of H2 2021/22 – pending national planning guidance and system ability to deliver ERF funding for the remainder of the financial year • Cash support requirement during H2, and steps taken to secure cash for Q3 			
Previously Considered By:			
<input checked="" type="checkbox"/> Finance, Performance & Investment Committee <input type="checkbox"/> Remuneration & Nominations Committee <input type="checkbox"/> Charitable Funds Committee		<input type="checkbox"/> Quality & Safety Committee <input type="checkbox"/> Workforce Committee <input type="checkbox"/> Audit Committee	
Strategic Objectives			
<input type="checkbox"/> SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services			
<input type="checkbox"/> SO2 Deliver services that meet NHS constitutional and regulatory standards			
<input checked="" type="checkbox"/> SO3 Efficiently and productively provide care within agreed financial limits			

<input type="checkbox"/> SO4 Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
<input type="checkbox"/> SO5 Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
<input type="checkbox"/> 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:
Andy Large, Deputy Director of Finance	John McLuckie, Director of Finance

Finance Report – Month 5 2021/22

1. Purpose

- 1.1. This report provides the Committee with the financial position for August 2021 (month 5).

2. Executive Summary

- 2.1. The Trust is required to break-even for the first half of the financial year ('H1')
- 2.2. In order to achieve financial breakeven, the H1 financial plan required a £3.7m CIP and relied upon a £0.8m contribution from Elective Recovery Funding (ERF).
- 2.3. At month 5, the Trust has delivered services at a £751,000 deficit, following an in-month adverse variance of £496,000.
- 2.4. The financial run rate has remained broadly consistent prior to month 5, with pressures being experienced as a result of slippage against H1 CIP plans and continued temporary staffing costs.
- 2.5. However, planned Elective Recovery Funding (ERF) of £358,000 per month has reduced to £nil following changes to ERF income thresholds effective from July as previously reported.
- 2.6. The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed system funding.
- 2.7. The Trust requires external cash support during H2, and has taken steps to secure cash for Q3

3. Income & Expenditure for Month 5

- 3.1. In order to achieve financial breakeven, the H1 financial plan required a £3.7m CIP and relied upon a £0.8m contribution from Elective Recovery Funding (ERF).
- 3.2. It should be noted that this has resulted in a CIP requirement of 3.2%; this is in excess of the 1.5% national efficiency requirement for H1, having taken account of existing cost pressures in order to achieve break even.
- 3.3. The following table illustrates performance to month 5

Table 1 Income & Expenditure Account – August 2021

INCOME & EXPENDITURE £000	IN MONTH			YEAR TO DATE			ANNUAL
	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Commissioning Income	(14,900)	(14,885)	(15)	(74,067)	(73,921)	(146)	(178,034)
NHSE/I Top up	(3,541)	(3,095)	(446)	(17,706)	(17,284)	(422)	(42,493)
PP, Overseas & RTA	(51)	(36)	(15)	(257)	(226)	(31)	(616)
Other Income	(969)	(958)	(11)	(4,556)	(4,430)	(126)	(10,502)
Total Operating Income	(19,461)	(18,974)	(487)	(96,585)	(95,860)	(725)	(231,645)
Pay	13,425	13,328	97	66,919	66,963	(44)	160,919
Non-Pay	5,702	5,829	(127)	27,992	28,066	(74)	66,708
Net Finance Costs	335	331	4	1,675	1,659	15	4,019
Technical Adjustments	0	(17)	17	0	(77)	77	0
Total Expenditure	19,461	19,471	(10)	96,585	96,611	(26)	231,645
(Surplus)/Deficit	0	497	(497)	0	751	(751)	0

- 3.4. At month 5, the Trust has delivered services at a £751,000 deficit.
- 3.5. Following changes in payment thresholds requiring trusts to deliver 95% elective recovery (up from 85%) from 1 July 2021, the Trust will receive £nil ERF funding for the remainder of H2 – resulting in reduced income of £775,000 for H1.
- 3.6. Non-NHS income is not recovering to the levels set in the H1 plan. Both car parking and catering levels are still under performing and is expected to continue beyond H1.
- 3.7. The H1 plan includes £1.9 million for Covid-19 costs which amount to £316,000 per month. Whilst Covid-19 expenditure has reduced from £397,000 in month 1 down to £135,000 in August, the financial run rate has not seen an overall reduction in total Trust expenditure.
- 3.8. Temporary staffing has increased from £2.2m in July to £2.4m in August on bank and agency driven by Other Medical and Nursing staffing predominantly in Medicine & Emergency Care.
- 3.9. The Medicine and Emergency Care CBU continue to incur significant bank and agency costs, which amounted to £1.3m in month 5, compared with £1.2m in month 4.
- 3.10. It is expected that the Trust's non-pay expenditure will continue at current levels – commensurate with activity restoration delivered to-date – noting that a reduction in clinical supplies was experienced in-month in line with activity.
- 3.11. The Trust is forecasting achievement of financial break even for H1 following non-recurrent mitigations including cash-backed system funding, details of which are covered later in this report.
- 3.12. Pending national planning guidance (originally due 16 September 2021) and confirmation of income and ERF (or equivalent) arrangements beyond H1, the current expenditure run rate is expected to result in a H2 deficit, which will require external cash support which is covered in Section 8 of this report.

4. Business Unit Budget Performance

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

Table 2 Business Unit Budgetary Performance

CLINICAL BUSINESS UNIT £000	IN MONTH			YEAR TO DATE			ANNUAL
	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Medicine & Emergency Care	4,841	5,400	(559)	23,755	26,552	(2,797)	57,000
Planned Care	4,814	4,897	(83)	23,920	24,034	(114)	56,947
Specialist Care	3,457	3,585	(128)	17,251	17,468	(217)	41,585
Corporate	(17,116)	(17,501)	385	(85,070)	(87,788)	2,718	(202,470)
Finance	546	565	(19)	2,731	2,676	55	6,556
Estates & Facilities	1,363	1,430	(67)	6,813	7,182	(369)	16,353
Human Resources	265	253	12	1,327	1,322	5	3,185
Nursing & Midwifery	451	489	(38)	1,935	1,928	7	4,787
Medical Director	726	742	(16)	3,624	3,734	(110)	8,693
Strategy	318	306	12	2,039	1,984	55	3,345
Financing Costs	335	331	4	1,675	1,659	16	4,019
(Surplus)/Deficit	0	497	(497)	0	751	(751)	0

- 4.2. It should be noted that 'Corporate' includes reserves (e.g. winter funding, and inflation) originally intended to be allocated into business units. However, this flexibility is already being fully utilised through the financial run rate across CBUs.
- 4.3. Investment priorities moving into H2 must therefore be considered in the context of the current financial trajectory of the Trust.
- 4.4. Medicine & Emergency Care CBU's adverse variance is mainly driven by the temporary staffing expenditure as referenced above in Section 3.9.
- 4.5. Bank, Overtime and Agency costs across all CBUs are set out in the context of year to date financial performance below.

Table 3 Income & Expenditure v Bank, Overtime & Agency Spend

MONTH 5 YTD £000	INCOME & EXPENDITURE			BANK, OVERTIME & AGENCY			
	Budget	Actual	Variance	Bank	Overtime	Agency	Total
Medicine & Emergency Care	23,755	26,552	(2,797)	(3,561)	(25)	(2,735)	(6,321)
Planned Care	23,920	24,034	(114)	(1,423)	(60)	(646)	(2,128)
Specialist & Support Services	17,251	17,468	(217)	(754)	(121)	(296)	(1,171)
Corporate	(85,070)	(87,788)	2,718	(151)	(0)	0	(151)
Finance	2,731	2,676	55	(18)	(15)	(17)	(50)
Estates & Facilities	6,813	7,182	(369)	(301)	(109)	(79)	(490)
Human Resources	1,327	1,322	5	(11)	(2)	(2)	(15)
Nursing & Midwifery	1,935	1,928	7	(17)	(0)	(56)	(73)
Medical Director	3,624	3,734	(110)	(0)	0	(17)	(17)
Strategy	2,039	1,984	55	(831)	(2)	(200)	(1,033)
Financing Costs	1,675	1,659	16	0	0	0	0
TOTAL	0	751	(751)	(7,066)	(335)	(4,047)	(11,449)

- 4.6. In response to the continued reliance on temporary staffing, the Trust is moving to establish a Premium Rate Pay Control Panel across the CBUs.
- 4.7. This will follow the remit and membership of an equivalent forum in place at St Helens & Knowsley Teaching Hospitals NHS Trust (StHK), in order to increase visibility, review and challenge of all bank overtime and agency expenditure to optimise use of Trust resources.
- 4.8. The Committee will be kept updated on the development and progress of this forum.

5. Activity Performance and Elective Recovery Fund (ERF)

- 5.1. The planned ERF contribution towards the financial gap was £0.8 million in H1, requiring total ERF income of £2.1m.
- 5.2. The table below illustrates income performance to month 5:

Table 4 ERF Income forecast

	Apr-21			May-21			Jun-21			Jul-21			Aug-21			Aug 21 YTD
	National Trajectory	Trust Actual	ERF Income	National Trajectory	Trust Actual	ERF Income	National Trajectory	Trust Actual	ERF Income	National Trajectory	Trust Actual	ERF Income	National Trajectory	Trust Actual	ERF Income	ERF Income
	%	%	£000	%	%	£000	%	%	£000	%	%	£000	%	%	£000	£000
Elective	70	66	0	75	76	0	80	78	0	95	89	0	95	66	0	0
Outpatient	70	96	444	75	96	485	80	99	414	95	99	0	95	92	0	1,343
System			32			0			0			0			0	32
Total			476			485			414			0			0	1,375

- 5.3. The Trust’s ERF income is dependent on ICS system performance. However, following a change in national guidance relating to ERF thresholds (95% requirement from 1 July compared to original 85%), no further ERF income is anticipated to be earned during H1.
- 5.4. Furthermore, indications from ICS provider organisations suggest that the system ability to attract ERF funding from H2 is at risk.

6. Forecast Outturn – H1

- 6.1. The financial run rate has remained broadly consistent prior to month 5, with pressures being experienced as a result of slippage against H1 CIP plans and continued temporary staffing costs.
- 6.2. However, planned Elective Recovery Funding (ERF) of £358,000 has reduced to £nil from month 5 following changes to ERF income thresholds as previously reported.
- 6.3. The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed system funding as outlined below.

Table 5 H1 Forecast

H1 FORECAST OUTTURN	Comment for month 5	H1 Forecast £000
Plan Surplus/(deficit)	H1 £4.5M (before CIP/ERF)	4,500
Income shortfall	Non NHS income (catering, car park)	451
CIP actual delivery	H1 requires £3.7M excluding ERF contribution CIP = £3.08M Month 5 YTD	(2,211)
ERF contribution	Noting £nil income M5 & M6	(713)
COVID underspend	Versus £1,896k budget	(612)
Non Pay underspend	Non pay forecast increased expenditure in M5&6	(455)
Reserves profiled	Excluding ERF and COVID (see above)	(3,574)
Medicine & Emergency Care CBU	Medical staff £1.4M; Nursing staff £0.6M	3,570
All other budgets	Planned, Specialist CBU's and Corporate	544
ICS Support	£0.5m agreed M5	(500)
Technical Adjustments	Non-recurrent technical adjustments	(1,000)
Forecast Surplus/(deficit)		0

- 6.4. The Trust has undertaken a forecast outturn review, taking into account the following risks identified to the delivery of H2:
- CIP – anticipated under-delivery as reported elsewhere on the FP&I agenda
 - Other Income – continued reduction in car parking and catering income
 - ERF – following national changes to payment thresholds from month 4
 - Covid Costs – acknowledgement that the lifting of restrictions from 19 July will likely lead to escalating cases requiring hospital care
 - ED & Paediatric Attendances – acknowledgement that attendances are likely to continue at higher levels than pre-Covid levels
 - Temporary staffing costs – acknowledgement that elective recovery, staff sickness rates and annual leave are likely to drive increased staffing costs at premium rates
 - National Pay Award – to be funded nationally once agreed, however acknowledgement that a residual financial gap could arise
- 6.5. The Trust is currently considering proposals following recent Nurse Establishment Reviews, seeking to increase establishments across a number of wards currently staffed utilising bank and agency, to improve quality, safety, continuity & morale whilst improving the run rate position.
- 6.6. The Committee will be kept updated following receipt of national planning guidance for H2, and the development of plans – with national plan submissions anticipated to be required by 11 November 2021.
- 7. CIP Delivery**
- 7.1. The Trust is currently anticipating a shortfall against CIP plans for H1, with a significant

proportion arising from non-recurrent run rate under-spends included under Technical Items as summarised below.

Table 6 CIP Delivery

CIP £000	H1		
	Target	Forecast	Variance
Medicine and Emergency Care			
Planned Schemes	395	104	(273)
Unidentified	629	0	(629)
Planned Care			
Planned Schemes	261	247	(14)
Unidentified	767	0	(767)
Specialist & Support Services			
Planned Schemes	133	117	(15)
Unidentified	508	0	(508)
CORPORATE			
Planned Schemes	349	461	112
Technical Items	0	1,281	1,281
Unidentified	636	0	(636)
TOTAL	3,678	2,211	(1,450)

7.2. CIP scheme delivery is being managed through the monthly Use of Resources and CBU Efficiency Group meetings. In addition, the Trust is taking steps to drive accountability and development of further schemes as outlined in the Use of Resources paper included on the FP&I agenda.

8. Cash

8.1. The cash balance at the end of August was £3.4m, which is £2.2m below planned cash balances of £5.6m.

8.2. The appendices show a breakdown of the movements between categories but in summary the main driver is the Trust improving its Better Payment Practice Code performance.

8.3. Frequency of payment runs have increased (from two non NHS per week to three) and pay through dates have improved (NHS increased from 7 days to 15 days) resulting in increased values of payments to suppliers.

8.4. Cash flow forecasts have been updated to reflect the Trust's cash support requirements, and steps have been taken to bring forward contract receipt dates for income as well as changes to payment dates for major NHS creditors to assist cash flow for the remainder of H2.

8.5. From October, Southport & Formby CCG will pay contract income to the Trust on the first of each month, consistent with the arrangements already in place with West Lancs CCG. In addition, the Trust has secured £1.0m per month in cash support from Liverpool CCG for Q3.

8.6. The Trust continues to work with regional colleagues and manage capital expenditure outflows in order to delay the requirement to draw down external loan support from DHSC. In advance of requiring further external cash support beyond Q3, this ensures that PDC dividend payments and financing costs are minimised in H2.

8.7. The current route for cash support is to apply for DHSC revenue support loans.

9. Debtors

- 9.1. Overall debt has significantly reduced now standing at £1.6 million compared to July's value of £3.2 million.
- 9.2. Debt over one year old continues to be a focus and this has reduced from £955,000 last month to £826,000 at the end of August.
- 9.3. Most of this debt is down to 10 customers, the majority of which are NHS.
- 9.4. One of the larger debtors, Isle of Man government has now paid, and this will be reflected in September's performance.
- 9.5. NHSE/I are monitoring at the greater than 90 day debt level and this is also on a downward trajectory.
- 9.6. The Finance team are tackling the higher value, older debt and engaging with our customers to drive these figures down.

10. Capital

- 10.1. Year to date expenditure to the end of July is £798,000.
- 10.2. In month spend was again relatively low at £217,000 with most of the spend being on e-prescribing and radiology works.
- 10.3. Actual spend to the end of August represents 11.6% and is well below the planned spend of 41.8%.
- 10.4. However, the majority of schemes have either started or there are plans in place and there is confidence with the forecasts and monthly operational dashboards that the Trust will fully utilise all its capital resources.
- 10.5. A forecast outturn column is provided in the appendices on the capital report to assure the Committee of this.
- 10.6. We are currently working on profiling capital spend over the remaining months of the financial year as this helps on our cash flow planning but will also ensure that we are accruing accurately against each scheme.
- 10.7. There will be a significant increase in capital spend over the coming months.

11. Better Payment Practice Code (BPPC)

- 11.1. The action plan submitted to NHSEI to improve BPPC has had a positive result, with year to date performance increasing from 66% in July to 78.6% in August.
- 11.2. In month performance improved from 56.6% in July to 76.1% in August.
- 11.3. All percentages are based on the total value of non NHS and NHS payments.
- 11.4. Note, conversely this improvement has had a detrimental effect on cash flow.
- 11.5. Measures undertaken include additional temporary resources to deal with the backlog,

increased frequency of payment runs, review of pay through dates, ensuring all relevant payments included in the calculation, escalation rules amended to 7 days, review of approval hierarchies and educating approvers by providing how to guides on the intranet.

- 11.6. There is still a backlog of mostly NHS invoices to resolve and it is aimed to be up to date by the end of September.
- 11.7. Some of these backlog invoices had not been put on hold so they will fail the BPPC as soon as they are paid.
- 11.8. It is expected that performance in September may be similar or slightly worse but after that the year to date performance will start to improve.
- 11.9. What can be seen from the significant improvement in figures however is that whilst we are dealing with current invoices in a timely manner, there are still some older invoices under query that are impacting performance.
- 11.10. The way the calculation on BPPC works means that the Trust will not be able to reach the cumulative 95% target by year-end, however, the commitment is that the Trust will achieve the 95% target on a monthly basis from March 2022.

12. Conclusion

- 12.1. The Trust is behind plan at month 5, with key drivers being CIP delivery, and pressures in the Medicine and Emergency Care CBU relating to temporary staffing costs.
- 12.2. The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed system funding.
- 12.3. The Trust requires external cash support during H2 and has taken steps to secure cash for Q3.

13. Recommendation

- 13.1. Committee to note:
 - Year to date deficit of £751,000 at Month 5
 - The Trust is forecasting to achieve breakeven for H1 but only through the use of £1.0m of technical adjustments, plus £0.5m cash-backed ICS funding
 - Key actions to address drivers of nursing and medical bank & agency expenditure specifically in the Medicine and Emergency Care CBU
 - Risks to delivery of H2 2021/22 – pending national planning guidance and system ability to deliver ERF funding for the remainder of the financial year
 - Cash support requirement during H2, and steps taken to secure cash for Q3

INCOME ANALYSIS

As at 31 August 2021

OPERATING INCOME	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £'000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioning Income	178,034	74,067	73,921	(146)	14,900	14,885	(15)
PP, Overseas & RTA	616	257	226	(31)	51	36	(15)
Other Income	10,502	4,556	4,410	(146)	969	938	(31)
NHSE/I Top up	42,493	17,706	17,284	(422)	3,541	3,095	(446)
S&T Fund	0	0	20	20	0	20	20
TOTAL INCOME	231,645	96,585	95,860	(725)	19,461	18,974	(487)

Analysis - PP, Overseas & RTA	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Overseas visitors	20	8	5	(3)	2	0	(2)
Private patients	46	19	28	9	4	(2)	(6)
RTA income	550	229	193	(36)	46	38	(8)
Total	616	257	226	(31)	51	36	(15)

Analysis - Other Income	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Training & Education	5,831	2,429	2,454	25	486	491	5
Income generation	1,702	762	741	(21)	134	132	(2)
Services to other bodies	435	260	235	(25)	130	128	(2)
R&D	300	132	132	0	24	24	0
Other income & charges	2,235	972	847	(125)	194	163	(31)
Total	10,502	4,556	4,410	(146)	969	938	(31)

Operating income

Commissioning income - Plan primarily made up of H1 block values, Core NHSE £9.820m, CCG £73.105m and COVID £6.289m. The COVID allocation has subsequently been reduced by £2.4m to reflect the overall System adjustment.

In month and YTD underperformance relates to high cost drugs and will be off-set by corresponding reduction in spend as excluded drugs still treated as pass through cost.

PP, Overseas, RTA income

PP, Overseas RTA - Private Patient income below plan in month have started to recover since June, whilst RTA income remains below plan.

Other income

Other income - YTD shortfall of £146k relates to Non-NHS income, particularly car parking and Catering income and this position is unlikely to significantly improve during H1.

NHSE/I Top up

NHSE/I Top up - H1 planned value is made up of £17.760m top-up, £0.641 system growth, £0.695 other support for non-NHS income / CNST and £2.150m elective recovery fund (ERF).

In month underperformance has resulted from a deterioration in the ERF position following national increase in target from 85% to 95% for Q2 of H1.

PAY Expenditure

As at 31 August 2021

Business Unit	(All)							
Level4 Name	(All)							
Subjective Class	PAY							
STAFF GROUP	STAFF TYPE	ANNUAL	YEAR TO DATE			IN MONTH		
		Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Consultants	Substantive	(19,865)	(8,312)	(7,627)	685	(1,678)	(1,513)	165
	Bank	(206)	(90)	(551)	(461)	(14)	(151)	(137)
	Agency	(76)	(32)	(1,562)	(1,530)	(6)	(256)	(250)
Consultants Total		(20,147)	(8,434)	(9,740)	(1,306)	(1,698)	(1,920)	(222)
Other Medical	Substantive	(19,252)	(8,112)	(7,632)	480	(1,624)	(1,520)	104
	Bank	(581)	(314)	(1,248)	(934)	(61)	(365)	(304)
	Agency	(1,128)	(515)	(1,125)	(610)	(109)	(177)	(68)
Other Medical Total		(20,961)	(8,941)	(10,005)	(1,064)	(1,794)	(2,063)	(269)
Nurses & Midwives	Substantive	(59,520)	(24,773)	(21,236)	3,537	(4,986)	(4,245)	741
	Bank	(1,393)	(975)	(4,667)	(3,692)	(118)	(1,110)	(992)
	Agency	(48)	(46)	(1,002)	(956)	(7)	(149)	(142)
Nurses & Midwives Total		(60,961)	(25,794)	(26,906)	(1,112)	(5,111)	(5,503)	(392)
Scientific, Technical & Therapeutic	Substantive	(19,501)	(8,122)	(7,333)	789	(1,705)	(1,471)	234
	Bank	(43)	(18)	(17)	1	(4)	(2)	2
	Agency	(20)	(8)	(108)	(100)	(2)	(24)	(22)
Scientific, Technical & Therapeutic Total		(19,564)	(8,149)	(7,458)	691	(1,711)	(1,498)	213
Other Staff	Substantive	(31,023)	(12,910)	(12,030)	880	(2,585)	(2,373)	212
	Bank	(234)	(171)	(583)	(412)	(20)	(129)	(109)
	Agency	(13)	(13)	(249)	(236)	0	(49)	(49)
Other Staff Total		(31,271)	(13,094)	(12,862)	232	(2,605)	(2,550)	55
Pay Reserves		(13,601)	(4,753)	255	5,008	(946)	255	1,201
Apprenticeship Levy	Substantive	(552)	(230)	(248)	(18)	(46)	(49)	(3)
Apprenticeship Levy Total		(552)	(230)	(248)	(18)	(46)	(49)	(3)
Pay CIP	Substantive	6,138	2,476	0	(2,476)	486	0	(486)
SUMMARY BY STAFF TYPE								
	Substantive	(157,176)	(64,736)	(55,850)	8,886	(13,084)	(10,917)	2,167
	Bank	(2,457)	(1,568)	(7,066)	(5,498)	(217)	(1,756)	(1,539)
	Agency	(1,286)	(615)	(4,047)	(3,432)	(124)	(655)	(531)
Total Pay Expenditure		(160,919)	(66,919)	(66,963)	(44)	(13,425)	(13,328)	97

RUN RATE Month on Month - £(000)

Class	STAFF GROUP	STAFF TYPE	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
PAY	Consultants	Substantive	(1,353)	(1,548)	(1,449)	(1,551)	(1,481)	(1,410)	(1,516)	(1,447)	(1,503)	(1,566)	(1,602)	(1,442)	(1,513)
		Bank	(80)	(113)	(62)	(130)	(70)	(130)	(106)	(96)	(86)	(109)	(115)	(90)	(151)
		Agency	(250)	(325)	(314)	(269)	(308)	(259)	(352)	(320)	(318)	(356)	(316)	(316)	(256)
	Other Medical	Substantive	(1,393)	(1,518)	(1,405)	(1,433)	(1,507)	(1,489)	(1,436)	(1,518)	(1,541)	(1,505)	(1,505)	(1,561)	(1,520)
		Bank	(218)	(205)	(115)	(310)	(189)	(319)	(275)	(243)	(316)	(247)	(160)	(160)	(365)
		Agency	(261)	(327)	(319)	(316)	(334)	(262)	(279)	(256)	(212)	(272)	(233)	(230)	(177)
	Nurses & Midwives	Substantive	(4,137)	(4,045)	(4,052)	(4,040)	(4,033)	(4,078)	(4,131)	(4,298)	(4,263)	(4,287)	(4,242)	(4,199)	(4,245)
		Bank	(730)	(662)	(791)	(982)	(937)	(1,279)	(1,066)	(1,108)	(933)	(824)	(809)	(991)	(1,110)
		Agency	(359)	(262)	(273)	(239)	(243)	(245)	(228)	(282)	(244)	(239)	(183)	(188)	(149)
	Scientific, Technical & Therapeutic	Substantive	(1,430)	(1,424)	(1,445)	(1,443)	(1,467)	(1,492)	(1,478)	(1,482)	(1,465)	(1,448)	(1,505)	(1,443)	(1,471)
		Bank	(9)	(2)	(6)	(5)	(4)	(5)	(5)	(6)	(5)	(4)	(4)	(2)	(2)
		Agency	(22)	(22)	(13)	(16)	(20)	(29)	(27)	(28)	(19)	(18)	(18)	(29)	(24)
	Other Staff	Substantive	(2,336)	(2,410)	(2,343)	(2,327)	(2,340)	(2,395)	(2,382)	(2,480)	(2,429)	(2,418)	(2,432)	(2,378)	(2,373)
		Bank	(52)	(62)	(69)	(103)	(109)	(108)	(132)	(144)	(116)	(117)	(94)	(127)	(129)
Agency		(33)	(96)	(66)	(87)	(92)	(116)	(71)	(77)	(61)	(22)	(50)	(68)	(49)	
Pay Reserves	Substantive	6	(110)	(99)	(274)	(21)	(111)	(122)	(3,219)	0	(0)	0	0	255	
Pay CIP	Substantive	0	0	0	0	0	0	0	0	0	0	0	0	0	
Apprenticeship Levy	Substantive	(44)	(49)	(46)	(45)	(47)	(47)	(47)	(50)	(48)	(44)	(52)	(54)	(49)	
PAY Total			(12,702)	(13,184)	(12,868)	(13,570)	(13,203)	(13,775)	(13,654)	(17,054)	(13,558)	(13,476)	(13,321)	(13,280)	(13,328)
NON-PAY	Supplies & Services Clinical		(2,053)	(2,341)	(2,263)	(2,321)	(2,402)	(2,132)	(2,112)	(6,041)	(2,134)	(2,297)	(2,312)	(2,449)	(2,300)
	Supplies & Services General		(370)	(200)	(246)	(209)	(208)	(206)	(181)	(155)	(176)	(210)	(203)	(201)	(201)
	Non-Executive Directors		(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(10)	(10)	(10)	(8)	(8)
	Establishment Expenses		(215)	(238)	(253)	(361)	(314)	(464)	(456)	(276)	(300)	(230)	(259)	(300)	(562)
	Premises & Fixed Plant		(1,120)	(1,046)	(1,014)	(1,110)	(1,200)	(1,323)	(1,228)	(1,042)	(1,082)	(1,147)	(1,185)	(1,217)	(1,136)
	Miscellaneous		(775)	(839)	(781)	(779)	(815)	(783)	(799)	(1,161)	(925)	(915)	(926)	(895)	(917)
	Services From Other NHS Bodies		(104)	(155)	(106)	(140)	(108)	(121)	(143)	(112)	(126)	(115)	(136)	(125)	(121)
	Non Pay Reserve		(310)	(10)	(10)	70	0	0	0	300	(11)	(11)	(11)	(11)	(11)
	Non Pay CIP														
Depreciation		(554)	(554)	(554)	(465)	(554)	(554)	(451)	(536)	(572)	(572)	(572)	(572)	(572)	
NON-PAY Total			(5,510)	(5,391)	(5,235)	(5,323)	(5,609)	(5,591)	(5,380)	(9,032)	(5,337)	(5,507)	(5,613)	(5,780)	(5,829)
NET FINANCE COSTS	Interest Payable		(89)	(89)	(75)	(105)	(87)	(87)	(87)	205	(62)	(63)	(63)	(63)	(63)
	Profit/Loss on Asset Disp		2	0	7	3	2	0	64	(10)	0	0	0	0	1
	Contingent rent		(80)	(80)	(80)	(80)	(80)	(80)	(80)	(91)	(86)	(86)	(86)	(86)	(86)
	Dividend Payment	Net Finance costs	(10)	(20)	(210)	(204)	(207)	(207)	127	(166)	(183)	(183)	(183)	(183)	(183)
NET FINANCE COSTS Total			(177)	(189)	(359)	(386)	(372)	(374)	24	(62)	(331)	(332)	(332)	(331)	
Grand Total			(18,389)	(18,763)	(18,462)	(19,278)	(19,184)	(19,740)	(19,010)	(26,147)	(19,226)	(19,315)	(19,266)	(19,392)	(19,488)

Class	STAFF TYPE	STAFF GROUP	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
PAY	Substantive		(10,687)	(11,105)	(10,840)	(11,114)	(10,897)	(11,023)	(11,112)	(14,494)	(11,248)	(11,269)	(11,339)	(11,077)	(10,917)
	Bank		(1,090)	(1,045)	(1,042)	(1,529)	(1,309)	(1,841)	(1,585)	(1,598)	(1,456)	(1,301)	(1,182)	(1,371)	(1,756)
	Agency		(925)	(1,033)	(985)	(927)	(997)	(911)	(957)	(962)	(854)	(906)	(801)	(832)	(655)
PAY Total			(12,702)	(13,184)	(12,868)	(13,570)	(13,203)	(13,775)	(13,654)	(17,054)	(13,558)	(13,476)	(13,321)	(13,280)	(13,328)

Aug 21- Pay increased by £48k from July 21

Medical staff increased by £183k from July 21 on medical bank expenditure.
 Nursing and midwifery increased by £125k from July 21. in Planned Care and Medicine & Emergency Care.
 ST&T - £23k increase from July 21 on substantive staff across within Medicine & Emergency Care.
 Other staff -reduced by £24k from July 21.

Non Pay increased by £49k from July 21.

Supplies & Services Clinical - decrease of £149k from July 21. in Planned Care and Medicine & Emergency Care.
 Establishment expenses - increase of £262k from July on travel & subsistence and work permits and visas.
 Premises & plant - decrease of £81k from July 21. in Estates & Facilities and Planned Care.
 Miscellaneous - increase of £22k from July 21 on Bad Debt provision.

SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST
BANK, OVERTIME & AGENCY
MONTH 5 2021/22

CBU & Cost Centre	Executive Lead	ADO	Budget Holder	Bank	Overtime	Agency	Total
Medicine and Emergency Care							
Older Peoples Care Medical Staff	Lesley Neary	Mark Carmichael	Alex Gardner	254	0	808	1,062
Emergency Department Nursing SDGH	Lesley Neary	Mark Carmichael	Kate Monaghan	449	0	152	601
A&E Medical Staff	Lesley Neary	Mark Carmichael	Karen Atherton	364	0	83	447
Acute Medical Unit	Lesley Neary	Mark Carmichael	Claire Beck	318	0	67	385
Ward 14B	Lesley Neary	Mark Carmichael	Paula McCallum	194	2	108	304
Cardiology Medical Staff	Lesley Neary	Mark Carmichael	Louise Hicks	62	0	239	301
Ward 7A	Lesley Neary	Mark Carmichael	Joanne Hazlehurst	248	0	52	300
Acute Medicine Medical Staff	Lesley Neary	Mark Carmichael	Kate Monaghan	86	0	191	278
Short Stay Unit	Lesley Neary	Mark Carmichael	Claire Beck	196	0	74	269
FESS Ward	Lesley Neary	Mark Carmichael	Sheena Walker	209	0	58	267
Stroke Ward	Lesley Neary	Mark Carmichael	Paula McCallum	188	0	60	248
Ward 15A	Lesley Neary	Mark Carmichael	Sheena Walker	174	0	55	229
Endocrinology/Diabetes Medical Staff	Lesley Neary	Mark Carmichael	Louise Hicks	115	0	94	210
Gastroenterology Medical Staff	Lesley Neary	Mark Carmichael	Louise Hicks	6	0	198	204
Ward 11B	Lesley Neary	Mark Carmichael	Joanne Hazlehurst	123	0	65	189
Stroke Medical Staff	Lesley Neary	Mark Carmichael	Alex Gardner	11	0	144	155
Ward 15B	Lesley Neary	Mark Carmichael	Joanne Hazlehurst	98	0	48	145
Rheumatology Medical Staff	Lesley Neary	Mark Carmichael	Alex Gardner	0	0	113	113
Paed A E Medical Staff	Lesley Neary	Mark Carmichael	Karen Atherton	109	0	0	109
7b	Lesley Neary	Mark Carmichael	Mark Carmichael	75	0	19	94
Medical Nursing Management	Lesley Neary	Mark Carmichael	Mark Carmichael	56	0	20	76
Patient Flow	Lesley Neary	Mark Carmichael	Alex Gardner	55	6	12	74
Ward 1	Lesley Neary	Mark Carmichael	Mark Carmichael	46	0	14	61
Ambulatory Care	Lesley Neary	Mark Carmichael	Kate Monaghan	48	0	0	48
Respiratory Medical Staff	Lesley Neary	Mark Carmichael	Louise Hicks	3	0	28	32
Medical Discharge Lounge	Lesley Neary	Mark Carmichael	Alex Gardner	23	0	0	24
Medical Day Unit	Lesley Neary	Mark Carmichael	Sheena Walker	21	2	0	23
Medical Outlier Team	Lesley Neary	Mark Carmichael	Mark Carmichael	0	0	22	22
Joint Health (MSK) Service	Lesley Neary	Mark Carmichael	Barry 0	2	0	9	11
Emergency Department Reception	Lesley Neary	Mark Carmichael	Karen Atherton	8	1	0	8
Spinal Injuries Rehab	Lesley Neary	Mark Carmichael	Barry 0	6	1	0	7
Discharge Facilitators	Lesley Neary	Mark Carmichael	Hazel Irizar	3	0	2	6
Acute Therapy Team	Lesley Neary	Mark Carmichael	Barry 0	0	4	0	4
Wheelchair services	Lesley Neary	Mark Carmichael	Barry 0	3	0	0	3
Orthopaedic rehab	Lesley Neary	Mark Carmichael	Barry 0	0	3	0	3
Hospital Alcohol Liaison Team	Lesley Neary	Mark Carmichael	Kate Monaghan	3	0	0	3
Dietetics	Lesley Neary	Mark Carmichael	Barry 0	0	1	0	1
Stroke Physio	Lesley Neary	Mark Carmichael	Barry 0	0	1	0	1
ESD	Lesley Neary	Mark Carmichael	Mark Carmichael	0	1	0	1
Frailty Practitioners	Lesley Neary	Mark Carmichael	Barry 0	0	1	0	1
Outpatient Physiotherapy	Lesley Neary	Mark Carmichael	Barry 0	0	0	0	0
Audiology	Lesley Neary	Mark Carmichael	Barry 0	0	0	0	0
Stroke Nurses	Lesley Neary	Mark Carmichael	Alex Gardner	0	0	0	0
Emergency Care Therapies	Lesley Neary	Mark Carmichael	Barry 0	0	0	0	0
General Medical Winter Covid Pressures	Lesley Neary	Mark Carmichael	Mark Carmichael	0	0	(0)	(0)
Medicine and Emergency Care Total				3,561	25	2,735	6,321
Planned Care							
Anaesthetics Med Staff	Lesley Neary	Helen Baythorpe	Mandy Marsh	186	0	296	481
Ward 14A	Lesley Neary	Helen Baythorpe	Kath Todd	220	0	82	302
Spinal Injuries Unit	Lesley Neary	Helen Baythorpe	Sandra Croston	184	2	25	211
Theatres ODGH	Lesley Neary	Helen Baythorpe	Donna Murphy - acting up	157	18	1	176
Gen Surgery Med Staff	Lesley Neary	Helen Baythorpe	Mandy Marsh	88	0	72	160
Short Stay Surgical 10B	Lesley Neary	Helen Baythorpe	D Murphy on secondment - send to I	85	0	19	104
Orthopaedic Med Staff	Lesley Neary	Helen Baythorpe	Mandy Marsh	64	0	31	96
Ophthalmology Med Staff	Lesley Neary	Helen Baythorpe	Emma Wright	(1)	0	92	91
ITU CCU	Lesley Neary	Helen Baythorpe	Angie Westwood	67	0	0	67
Theatres SDGH	Lesley Neary	Helen Baythorpe	Donna Murphy - acting up	42	25	1	68
G Ward (Orthopaedic Rehab)	Lesley Neary	Helen Baythorpe	Helen Hurst	50	1	9	60
Urology Med Staff	Lesley Neary	Helen Baythorpe	Mandy Marsh	54	0	0	54
11A Surgical Ward	Lesley Neary	Helen Baythorpe	Nicky Orr	24	0	9	33
Access	Lesley Neary	Helen Baythorpe	Debbie Foster	26	4	0	29
E Ward	Lesley Neary	Helen Baythorpe	Helen Hurst	24	0	3	28
ENT Ophthalmology Outpatients	Lesley Neary	Helen Baythorpe	Colette Bricklebank/matron Helen Hi	19	2	0	21
Dermatology	Lesley Neary	Helen Baythorpe	Chris Corfield LTS send to Helen Bay	18	0	0	18
H Ward (Elective Orthopaedics)	Lesley Neary	Helen Baythorpe	Helen Hurst	13	0	3	16
Trackers	Lesley Neary	Helen Baythorpe	Debbie Foster	15	0	0	15
RMO	Lesley Neary	Helen Baythorpe	Helen Baythorpe	12	0	0	12
Surgical Assessment Unit	Lesley Neary	Helen Baythorpe	D Murphy on secondment - send to I	8	0	0	8
SIU Outreach Team	Lesley Neary	Helen Baythorpe	Kim Woods	8	0	0	8
Access - Paediatrics A and E	Lesley Neary	Helen Baythorpe	Suzanne Hogan	8	0	0	8
G Ward (Elective Orthopaedics)	Lesley Neary	Helen Baythorpe	Helen Baythorpe	6	0	2	8
Medical Records	Lesley Neary	Helen Baythorpe	Martin Graham	5	2	0	6
Treatment Centre	Lesley Neary	Helen Baythorpe	Chris Corfield	4	2	0	6
Maxillo Facial Orthodont	Lesley Neary	Helen Baythorpe	Helen Hurst	6	0	0	6
OPD Fracture Clinic SDGH	Lesley Neary	Helen Baythorpe	Chris Corfield	6	0	0	6
Medical Staff SIU	Lesley Neary	Helen Baythorpe	Helen Baythorpe	5	0	0	5
SIU Medical Staff	Lesley Neary	Helen Baythorpe	Kim Woods	4	0	0	5
Appliances	Lesley Neary	Helen Baythorpe	Chris Corfield	4	0	0	4
Plastertech Service	Lesley Neary	Helen Baythorpe	Chris Corfield	3	0	0	3
HSDU	Lesley Neary	Helen Baythorpe	Praph Chohan	0	3	0	3
F WARD SURGICAL DAYCASE ODGH	Lesley Neary	Helen Baythorpe	Gill Halsall	3	0	0	3
P Care Restoration EL	Lesley Neary	Helen Baythorpe	Helen Baythorpe	2	0	0	2
Critical Care Outreach Team	Lesley Neary	Helen Baythorpe	Angie Westwood	1	0	0	2
Orthoptists	Lesley Neary	Helen Baythorpe	Helen Hurst matron	1	0	0	1
Endoscopy Scheduling	Lesley Neary	Helen Baythorpe	Chris Corfield	0	1	0	1
SIU Intermediate Care Team	Lesley Neary	Helen Baythorpe	Helen Baythorpe	1	0	0	1
Surg Nurse Management	Lesley Neary	Helen Baythorpe	Stephen Mellors	0	0	0	0
OPD ODGH	Lesley Neary	Helen Baythorpe	Chris Corfield	0	0	0	0
Optometrists	Lesley Neary	Helen Baythorpe	Helen Hurst	0	0	0	0
OPD SDGH	Lesley Neary	Helen Baythorpe	Chris Corfield	0	0	0	0
OPD Fracture Clinic ODGH	Lesley Neary	Helen Baythorpe	Chris Corfield	0	0	0	0
Planned Care Total				1,423	60	646	2,128

SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST
BANK, OVERTIME & AGENCY
MONTH 5 2021/22

CBU & Cost Centre ED00	Executive Lead	ADO	Budget Holder	Bank	Overtime	Agency	Total
Specialist							
Maternity Services	Lesley Neary	Gareth Hobson	Janet Calland	314	12	0	327
Radiology Medical Staff	Lesley Neary	Gareth Hobson	David Moran	131	0	47	178
Paediatric Med Staff	Lesley Neary	Gareth Hobson	Graeme Seddon	57	0	90	147
Obs Gynae Medical Staff	Lesley Neary	Gareth Hobson	Jenny Large	67	0	58	125
Radiology	Lesley Neary	Gareth Hobson	David Moran	1	62	31	94
Neonatal Ward	Lesley Neary	Gareth Hobson	Shirley Coward	69	0	0	69
ECG	Lesley Neary	Gareth Hobson	David Moran	2	1	47	50
Pharmacy	Lesley Neary	Gareth Hobson	John Williams	5	41	0	47
Paediatric Unit	Lesley Neary	Gareth Hobson	Shirley Coward	40	0	0	41
Paediatric A and E Nursing	Lesley Neary	Gareth Hobson	Shirley Coward	35	0	0	36
Specialist and Support Administration	Lesley Neary	Gareth Hobson	Jenny Large	0	0	22	22
Gynae Clinics	Lesley Neary	Gareth Hobson	Wendy Hicks	13	4	0	17
Paeds A and E EPNPs	Lesley Neary	Gareth Hobson	Shirley Coward	9	0	0	9
Sexual Health Sefton New Contract	Lesley Neary	Gareth Hobson	Wendy Hicks	6	0	0	6
Children's Community & Outreach Team	Lesley Neary	Gareth Hobson	Shirley Coward	3	0	0	3
Cancer Services	Lesley Neary	Gareth Hobson	David Moran	2	0	0	2
Paediatric Clinics	Lesley Neary	Gareth Hobson	Shirley Coward	0	0	0	0
Specialist Total				754	121	296	1,171
Corporate							
Coronavirus	Lesley Neary	Chrisella Morgan	Greg O'Neil	798	2	125	924
Central Reserves	Ann-Marie Stretch	John McLuckie	Andy Large	145	0	0	145
Domestics SDGH	John McLuckie	Chris Davies	Pauline Milton	91	11	37	139
Domestics ODGH	John McLuckie	Chris Davies	Pauline Milton	74	15	0	89
Porters SDGH	John McLuckie	Chris Davies	Pauline Milton	35	18	0	54
Strategic Operational Management	Lesley Neary	Chrisella Morgan	Lesley Neary	0	0	46	46
Re-active Engineering Maintenance SDGH	John McLuckie	Chris Davies	Steve Scott	0	2	43	45
COVID Vaccines	Lesley Neary	Chrisella Morgan	Greg O'Neil	33	0	11	44
Integrated Governance	Bridget Lees	Simon Regan / Lynne Barnes	Mandy Power	0	0	29	29
Laundry	John McLuckie	Chris Davies	Pauline Milton	6	22	0	28
Health Safety and Fire	Bridget Lees	Simon Regan / Lynne Barnes	John Buck	0	0	27	27
Logistical Services	John McLuckie	Chris Davies	Terry Kelly	16	10	0	26
Catering ODGH	John McLuckie	Chris Davies	Angela Wakefield	22	2	0	24
Management Accounting	John McLuckie	Andy Large	Alison Brown/ Sarah Huyton	13	0	9	22
Porters ODGH	John McLuckie	Chris Davies	Pauline Milton	8	11	0	19
Information	Lesley Neary	Chrisella Morgan	Mike Lightfoot	0	0	19	19
Medical Director	Kate Clark	Kevin Thomas	Kevin Thomas	0	0	17	17
Car Park ODGH	John McLuckie	Chris Davies	Angela Hunt	15	0	0	15
Human Resources	Jane Royds	Sonya Clarkson	Sonya Clarkson	11	0	2	13
Clin Practice Facilitator	Bridget Lees	Simon Regan / Lynne Barnes	Claire Blackman	12	0	0	12
Re-active Engineering Maintenance ODGH	John McLuckie	Chris Davies	Ian Bland	0	12	0	12
IT	John McLuckie	Paul Chadwick	Levitt Parkes	0	12	0	12
Catering SDGH	John McLuckie	Chris Davies	Angela Wakefield	8	2	0	10
Administration and Compliance	John McLuckie	Chris Davies	Pauline Milton	9	0	0	9
Financial Services	John McLuckie	Andy Large	Mark Wilson	0	0	8	8
Medical Devices Library	John McLuckie	Chris Davies	Chris Hough	8	0	0	8
Ward Catering Assistant	John McLuckie	Chris Davies	Angela Wakefield	5	0	0	5
Telephonists	John McLuckie	Chris Davies	Angela Hunt	4	1	0	5
EPR and Systems	John McLuckie	Paul Chadwick	Clair Gahan	1	4	0	4
Procurement	John McLuckie	Andy Large	Jon Hannah	4	0	0	4
Information Governance	Ann-Marie Stretch	Ann-Marie Stretch	Stephen Brookes	4	0	0	4
Painting Southport	John McLuckie	Chris Davies	Steve Scott	0	3	0	3
PR & Comms	Ann-Marie Stretch	Ann-Marie Stretch	Tony Ellis	2	0	0	2
Occupational Health	Jane Royds	Sonya Clarkson	Linda Lewis	0	2	0	2
Safeguarding	Bridget Lees	Simon Regan / Lynne Barnes	Sharon Seton	2	0	0	2
Director Of Nursing	Bridget Lees	Simon Regan / Lynne Barnes	Claire Blackman	2	0	0	2
International Nursing Recruitment	Bridget Lees	Simon Regan / Lynne Barnes	Carol Fowler	1	0	0	1
Resus Training	Bridget Lees	Simon Regan / Lynne Barnes	Angie Westwood	0	0	0	0
Facilities Management	John McLuckie	Chris Davies	Sue Pearson	0	0	0	0
Estates Management	John McLuckie	Chris Davies	Sue Pearson	0	0	0	0
E-Rostering Team	Jane Royds	Sonya Clarkson	Andrea Padgeon	0	0	0	0
EBME ODGH	John McLuckie	Chris Davies	Chris Hough	0	0	0	0
PGMC	Kate Clark	Kevin Thomas	Ann Holden	0	0	0	0
Chaplains	Bridget Lees	Simon Regan / Lynne Barnes	Claire Blackman	0	0	0	0
PMO	Lesley Neary	Chrisella Morgan	Donna Lynch	0	0	0	0
Recruitment and Resourcing	Jane Royds	Sonya Clarkson	Andrea Padgeon	0	0	0	0
Company Secretary	Ann-Marie Stretch	Ann-Marie Stretch	Sharon Kaetema	0	0	0	0
Patchwork Bank	Ann-Marie Stretch	Jane Royds	Sonya Clarkson	(0)	0	0	(0)
Corporate Total				1,329	129	370	1,828
Grand Total				7,066	335	4,047	11,449

NON-PAY Expenditure

As at 31 August 2021

EXPENSE GROUP	ANNUAL	YEAR TO DATE			IN MONTH		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Supplies & Services Clinical	(27,715)	(11,582)	(11,493)	89	(2,313)	(2,300)	13
Supplies & Services General	(2,425)	(1,031)	(990)	41	(203)	(201)	2
Establishment Expenses	(3,718)	(1,538)	(1,651)	(113)	(440)	(562)	(122)
Premises & Fixed Plant	(13,300)	(5,632)	(5,768)	(136)	(1,112)	(1,136)	(24)
Miscellaneous	(11,036)	(4,637)	(4,579)	58	(924)	(917)	7
Services From Other NHS Bodies	(1,524)	(660)	(624)	36	(127)	(121)	6
Non-Executive Directors	(99)	(41)	(45)	(4)	(8)	(8)	0
Depreciation	(6,754)	(2,814)	(2,862)	(48)	(563)	(572)	(9)
Non Pay Reserve	(137)	(57)	(53)	4	(11)	(11)	0
NON-Pay Total	(66,708)	(27,992)	(28,066)	(74)	(5,702)	(5,829)	(127)

Non Pay overspent in month by £127k.

Supplies & Services Clinical - £13k underspend in month. Underspend on Hearing aids and Medical gases offset by an overspend on Medical & surgical disposable equipment.

Supplies & Services General - No material movement in month.

Establishment expenses - overspend in month of £122k of which £102k relates to work visa & permits and £44k on training expenses for International Nurse Recruitment. Some of this overspend is offset by an underspend on travel & subsistence.

Premises & Fixed Plant - overspend in month of £19k on independent sector.

Miscellaneous - underspend of £11k relating to Bad Debt Provision.

Statement of Financial Position (Balance Sheet)

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2021	31/08/2021		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	105,813	103,753	(2,060)	(356)
Other assets	1,338	1,010	(328)	18
TOTAL NON CURRENT ASSETS	107,151	104,763	(2,388)	(338)
CURRENT ASSETS				
Inventories	2,980	2,993	13	151
Trade and other receivables	8,483	10,622	2,139	(1,366)
Cash and cash equivalents	6,352	3,414	(2,938)	(1,688)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	17,815	17,029	(786)	(2,903)
CURRENT LIABILITIES				
Trade and other payables	(22,914)	(21,102)	1,812	2,648
Provisions	(545)	(823)	(278)	(1)
PFI/Finance lease liabilities	(459)	(459)	0	0
DHSC revenue loans	0	0	0	0
DHSC Capital loan	(405)	(400)	5	0
Other liabilities	(1,608)	(1,638)	(30)	19
TOTAL CURRENT LIABILITIES	(25,931)	(24,422)	1,509	2,666
NET CURRENT ASSETS/(LIABILITIES)	(8,116)	(7,393)	723	(237)
TOTAL ASSETS LESS CURRENT LIABILITIES	99,035	97,370	(1,665)	(575)
NON CURRENT LIABILITIES				
Provisions	(450)	(158)	292	(8)
DHSC revenue loans	0	0	0	0
PFI/Finance lease liabilities	(12,719)	(12,373)	346	69
DH Capital loan	(200)	0	200	0
TOTAL NON CURRENT LIABILITIES	(13,369)	(12,531)	838	61
TOTAL ASSETS EMPLOYED	85,666	84,839	(827)	(514)
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	236,540	236,540	0	0
Retained earnings	(153,543)	(154,370)	(827)	(514)
Revaluation reserve	2,669	2,669	0	0
TOTAL TAXPAYERS EQUITY	85,666	84,839	(827)	(514)



**Southport and
Ormskirk Hospital**
NHS Trust

In line with the national push on ensuring prompt payments to suppliers the major movement this month has been a significant reduction in trade and other payables (£2.6m)

To help fund the above, the Trust received significant monies from customers and this is reflected in the reduction in Trade and other receivables (£1.3m). This explains why our cash resources have not reduced in line with the payments to suppliers.

Performance against plan as at the end of August 2021

	Year to date performance			Note
	Plan £'000s	Actual £'000s	Variance £'000s	
Opening Cash (Apr-21)	6,352	6,352	0	
Operating surplus/(deficit)	1,621	835	(786)	a
Non cash - Depreciation	2,789	2,862	73	
Movements in working balances	100	(2,330)	(2,430)	b
Capital expenditure	(4,431)	(3,311)	1,120	c
DHSC capital loans repaid	(200)	(200)	0	
PDC received	200		(200)	d
PFI/finance lease capital payments	(249)	(249)	0	
Interest payments	(545)	(545)	0	
PDC dividend (paid)/refunded	0	0	0	
Closing balance	5,637	3,414	(2,223)	

Notes

- a) Operating surplus which is the amount before interest payable and dividend payments is £786k adversely away from plan.
- b) Largest movement as Trust is processing a backlog of supplier invoices so the Trust can achieve an improved Better Payment Practice Code percentage.
- c) Capital spend remains low but all major schemes have started and spend will increase. Note cash outflows on capital include a large element of 20/21's capital creditor of £3.5m.
- d) At this point the Trust had expected to be able to draw down public dividend capital to support fire safety projects which are part of the emergency capital bid.