NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE

To be held at 0900 on Wednesday 03 November 2021

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
SO016/21	**Patient Story** *Purpose: To **receive** the patient story*	No	DoN	10 mins
SO017/21 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
SO018/21 (V)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO019/21 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 06 October 2021.*	No	*Chair*	10 mins
SO020/21 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
RISK AND GOVERNANCE				***0920***
SO021/21 (D)	**Board Assurance Framework** *Purpose: To **receive** the Board Assurance Framework*	*No*	*ADCG*	10 mins
INTEGRATED PERFORMANCE REPORT				**0940**
SO023/21 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Workforce c) Operations d) Finance *Purpose: To **receive and note** the IPR for assurance.*	*No*	*Lead Executive*	20 mins

WORFORCE				**1000**
SO024/21 (D)	**Workforce Committee AAA Highlight Report** *Purpose: To **receive** the reports for information and assurance*	*No*	*Cttee Chair*	5 mins
SO025/21 (D)	**Gender Pay Gap Report** *Purpose: To **note** the Gender Pay Gap Report*	*No*	*DoHR*	10 mins
FINANCE, OPERATIONS AND INVESTMENT				**1015**
SO026/21 (D)	**Finance, Performance and Investment Committee AAA Report** *Purpose: To **receive** the AAA report for information and assurance*	*No*	*Cttee Chair*	5 mins
SO027/21 (D)	**EPRR Statement of Compliance with Core Standards** *Purpose: To **receive** the EPRR Report*	*No*	*COO*	5 mins
SO028/21 (D)	**Winter Plan** *Purpose : To **approve** the Winter Plan*	*No*	*COO*	5 mins
QUALITY & SAFETY				**1035**
SO029/21 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the AAA Report for information and assurance*	*No*	*Cttee Chair*	5 Mins
SO030/21 (D	**Learning from Deaths Report** *Purpose: To **receive** the Learning from Deaths report*	*No*	*MD*	10 mins
SO031/21 (D	**Summary Report of changes to IPC Assurance Framework** *Purpose: To **receive** and **note** the IPC Assurance Framework*	*No*	*DoN*	5 mins
CONCLUDING BUSINESS				**1055**
SO032/21 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*10 mins*
SO033/21 (V)	**Any Other Business**		*Chair*	

*Purpose: To **receive** any urgent business not included on the agenda*

Date and time of next meeting: ***1100***
0930 Wednesday 01 December 2021 ***close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

The Board of Directors through its delegation to 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: Richard Fraser

Draft Minutes of the Strategy and Operations Committee
Held on Microsoft Teams
Wednesday 06 October 2021
(Subject to the approval of the Strategy and Operations Committee on 03 November 2021)

Present

Mr Richard Fraser	Chair
Mrs Gill Brown	Non-Executive Director, StHK
Ms Nicola Bunce	Director of Corporate Services, StHK
Dr Kate Clark	Medical Director, S&O
Mr Ian Clayton	Non-Executive Director, StHK
Mr Rob Cooper	Director of Operations and Performance, StHK
Mrs Val Davies	Non-Executive Director, StHK
Mr Nikhil Khashu	Director of Finance and Information, StHK
Ms Bridget Lees	Director of Nursing, Midwifery and Therapies, S&O
Ms Ann Marr	Chief Executive Officer
Mr John McLuckie	Director of Finance, S&O
Mrs Lesley Neary	Chief Operating Officer, S&O
Mrs Sue Redfern	Director of Nursing, Midwifery and Governance, StHK
Mr Rowan Pritchard Jones	Medical Director, StHK
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Nina Russell	Director of Transformation
Mrs Anne-Marie Stretch	Managing Director
Mrs Christine Walters	Director of Informatics, StHK

In Attendance

Mr Tony Ellis	Communications and Marketing Manager *(Part 1 only)*
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance *(minute taker)*

Apologies

Mr Paul Growney	Non-Executive Director, StHK
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Lisa Knight	Associate Non-Executive Director
Mr Jeff Kozer	Non-Executive Director, StHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO001/21	**Chair's welcome and note of apologies** Mr Fraser welcomed all to the first Strategy and Operations Committee meeting. Apologies for absence were noted from Mr Growney, Mrs Katema, Mrs Knight and Mr Kozer.	
SO002/21	**Declaration of interests** There were no declarations of interests in relation to the agenda items.	
STRATEGIC CONTEXT		
SO003/21	**Chair's Introduction to the Agreement for Long Term Collaboration (ALTC)** Mr Fraser welcomed members to the new committee and commented that the	

new arrangement would be great for patients and staff and would provide more opportunities for staff development.

RESOLVED:
The Strategy and Operations Committee **noted** the Terms of Reference

SO004/21 Chief Executive's Introduction

Ms Marr presented the Agreement for Long Term Collaboration (ALTC) and advised that:

- All items that can be delegated by the Southport and Ormskirk (S&O) NHS Trust Board have been delegated to St Helens and Knowsley (StHK) Teaching Hospitals NHS Trust
- The S&O Board appointed Ms Marr as the new Chief Executive Officer (CEO) and Mrs Stretch as the Managing Director
- The governance of S&O would be undertaken by the Strategy and Operations Committee which would consist of the StHK Non-Executive Directors, StHK Executive Directors and S&O Executive Directors
- The effectiveness of the ALTC would be overseen by a quarterly Joint Performance meeting with representatives of NHSE, StHK and S&O in attendance
- The S&O Board would retain the statutory functions i.e. audit, management of charitable funds, Board level appointments and remuneration and would continue to meet four times a year to discharge these responsibilities
- Intention in the ALTC was for a formal transaction by April 2023 (subject to statutory transaction process and approvals)

RESOLVED
The Strategy and Operations Committee **received** the update on the ALTC

INTEGRATED PERFORMANCE REPORT

SO005/21 Integrated Performance Report (IPR)

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

a) Quality and Safety Performance Report

Dr Clark and Ms Lees jointly presented the Quality and Safety Performance Report which provided an overview of performance against the quality and safety standards. The report outlined that:

- Mortality screening performance had declined due to the transition period following the introduction of the medical examiner role. The medical examiner would be conducting retrospective reviews to ensure improvement in screening rates.

- An audit had been conducted following an increase in Caesarean and Induction rates and an action plan based on the findings had been presented at the recent Quality and Safety (Q&S) Committee meeting which would bring rates back within the expected range.
- The slight increase in the number of Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E.coli) infections and the root causes were being investigated.
- Three cases of Clostridium difficile (C.Diff) were reported and investigated in August and identified that there were no apparent lapses in care.

In response to Mr Cooper's query around the application of the latest IPC guidance, Ms Lees advised that the IPC team was applying broader principles and reviewing the latest guidance jointly with the Operations Teams and regional DoN Group. Once the review was completed, the regional guideline for the North West would be adopted.

Ms Lees advised that the Safe Staffing target had not been met due to high sickness rates and annual leave over the summer period. Additionally, three breaches of 1:1 care were reported in Maternity in the preceding two months due to staffing pressures and high levels of activity. She advised that the decrease in safe staffing had been as a result of increased demand and the team would be reviewing projections of activity going forward as well as staffing requirements for October.

Mrs Redfern asked about the identification of patients with Sepsis within the one hour time frame. Dr Clark advised that junior doctors conducted an audit which had highlighted the delay in the administration of antibiotics and as a result the Antibiotics Policy was being reviewed.

Dr Clark advised that whilst several root cause analyses were completed weekly around the effect of gall stones and stents, initial reviews had not highlighted any lapses in care. Furthermore, a clinical review of patients' history had highlighted that patients had received the appropriate antibiotic treatment during prior attendances for the same condition. The team was reviewing the lessons learnt to ensure that action was taken earlier in the pathway.

Dr Clark noted Mr Pritchard Jones' recommendation of Copeland's Risk Adjusted Barometer (CRAB) to review expected outcomes and patients' needs.

RESOLVED
The Strategy and Operations Committee **received** and **noted** the Quality and Safety Performance Report

b) Workforce Performance Report

Mrs Royds presented the Workforce Performance report advising that:

- There was a notable improvement on compliance with Personal

Development Reviews (PDRs) across Clinical Business Units (CBUs) and Corporate Services.

- Sickness absence rates remained at 6% for two consecutive months. The main causes cited related to anxiety and depression which were mainly due to external factors such as bereavement.
- In addition, work to provide support to staff that were currently on long term sick was ongoing.

Mrs Davies queried whether the StHK partnership had created additional anxiety for staff. Mrs Royds advised that there had been a positive response and provided assurance that staff were being supported where necessary.

RESOLVED
The Strategy and Operations Committee **received and noted** the Workforce Performance Report

c) Operational Performance Report

Mrs Neary presented the report which provided a summary of operational activity against the constitutional standards. It was noted that performance against constitutional standards failed to meet national targets as the Trust continued its recovery from the impact of the pandemic. This included performances in ED, Diagnostic, RTT and Cancer. She highlighted that:

- there had been a 21.6% increase in demand for Urgent and Emergency Care services (April to August) when compared to the corresponding period in 2019/20, although it was noted a large proportion of the attendances could have appropriately been treated by Primary Care. However, the Trust had continued to perform well when compared to other trusts in the region.
- Ambulance handover times had remained satisfactory and corridor care remained at zero despite increasing demand.
- The surge in the number of Covid-19 cases during August and the higher proportion of primary care attendances had resulted in the introduction of initiatives which sought to cope with the increase in demand. These included:
  - Pausing the ward refurbishment programme
  - Transferring of the Discharge Lounge to the Escalation ward and transferring the Escalation ward to Ward 1 to create additional bed capacity
  - Increased focus on patients with length of stay greater than 21 days
- Whilst a decline in elective restoration activity had been recorded in August, the position had improved in September.
- Endoscopy service remained challenged as wait times in Endoscopy increased due to the demand of the 2week waits. Overall, the waiting list increased by 140%, new additions increased by 20% and Trust activity increased by 10%. The Trust had deployed additional Waiting List Initiatives (WLI) clinics as well as virtual consultations with a view to reducing the number of patients on the waiting list, however the constraints

of the estate meant that lists had to be single sex, which limited capacity.

With regards to Stroke Services, this remained an area of increased focus within the CBU with ring-fencing of stroke beds to ensure a direct pathway from ED. In response to Mrs Brown's comment that both Stroke services and ED had reported issues with the delay of overnight swabs, Mrs Neary advised that an audit was being conducted to understand the reasons for any delays.

Ms Marr commented that most trusts in the Cheshire and Mersey (C&M) region were performing well under challenging circumstances.

Mr Clayton queried if gynaecology referrals were outpacing available appointments and Mrs Neary responded that risk assessments were carried out to ensure high risk patients were given clinical priority. Additional WLI sessions had been set up which were expected to result in an improvement in the coming months.

Mr Clayton commented that he had found some of the reports more difficult to understand and referenced the Cost Improvement Programme (CIP) report as an example. Mrs Neary advised that the Trust had adopted the Statistical Process Control (SPC) reporting methodology in line with NHSE guidelines which had resulted in the Trust moving away from RAG rating guidance. She offered to arrange a training session facilitated by NHSE if members would find it useful. Mr Khashu commented that StHK were in the process of refreshing the format of their IPR and would work with Mr McLuckie and Mrs Neary on a format to ensure that there was a standardised approach across the two Trusts.

RESOLVED
The Strategy and Operations Committee **received and noted** the Operational Performance Report

d) Financial Performance Report

Mr McLuckie presented the report which detailed performance against financial indicators and highlighted that the planned Elective Recovery Funding (ERF) of £358,000 had reduced to zero from month five following changes to the ERF income thresholds. In response to Ms Marr's query around the amendment to the forecast outturn for the year, Mr McLuckie advised that as part of the H1 forecast only a marginal achievement of ERF had been forecast and that as the forecast for H2 had assumed that the Trust would not achieve over 89% of costs the impact would remain the same.

It was noted that premium rate staffing costs had adversely affected the financial run rate as a result of recruitment and sickness absence. This was mainly due to MEC CBU requiring temporary staff following changes to the Acute Medical Unit (AMU) and ED.

RESOLVED
The Strategy and Operations Committee **received and noted** the Financial Performance Report

QUALITY AND SAFETY

SO006/21 Quality and Safety Reports

a) Committee AAA Highlight Report

Mrs Brown presented the AAA Highlight report and alerted the Committee that the Annual Resuscitation Report had highlighted further resources were required to ensure that all the Quality Standards of the UK Resuscitation Council were met. She advised that the Integrated Governance Annual Report had highlighted the outstanding actions concerning the testing of fire and smoke dampers on certain wards and provided assurance that there was an action plan in place to resolve this. The Committee had requested a report at the next meeting on the Lost to follow up and Clinical Harm reviews.

The Committee had received assurance from the Short Stay Therapy Model presentation which had described the successful implementation of a step down rehabilitation facility to support patient flow during the pandemic and included system collaboration with the local Clinical Commissioning Groups (CCG) and nursing homes.

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

b) Summary Report of changes to IPC Assurance Framework

Ms Lees presented the report which provided an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Framework. One further action had been completed since the last report and three remained in progress. She advised that the review being undertaken by the ventilation Task and Finish Group was nearing completion and that a report would be issued once completed.

RESOLVED:
The Strategy and Operations Committee **received** the Summary Report of changes to IPC Assurance Framework

c) Safe Nursing and Midwifery Staffing Report

Ms Lees presented the bi-annual Safe Nursing and Midwifery Staffing Report which provided the Committee with a comprehensive update on staffing for nursing and midwifery as well as the Allied Health Professionals (AHPs). It was

noted that there were currently 96 band 5 WTE vacancies but progress had been made in the recruitment of international nurses and a total of 90 nurses were expected to be in post by November 2021 with further appointments planned for the following year. Furthermore, the Trust was working with local university partners to increase the number of local placements.

RESOLVED:
The Strategy and Operations Committee **received** the Safe Nursing and Midwifery Staffing Report for assurance

d) Annual Reports 2020/21

Dr Clark presented the Medical Appraisal and Revalidation Annual Report and declaration which provided assurance that appropriate processes were in place to ensure that the Trust remained compliant with its legal obligations. It was noted that whilst NHSE had formally suspended medical appraisals between March and October 2020 the report outlined that:

- 60.36% of doctors had completed a medical appraisal in the required timescales in line with GMC requirements
- 18.9% appraisals were not completed due to Covid-19
- one unapproved missed or late appraisal

Dr Clark advised that, whilst additional staff had been trained as appraisers, further additional appraisers would be required as there would be an increased focus on the quality of appraisals going forward.

Ms Lees presented the Safeguarding Annual Report, which provided assurance to the Committee on safeguarding activity within the Trust and compliance with statutory duties for Safeguarding and the robustness of processes in place to safeguard those who use Trust services as well as highlight areas of challenge in safeguarding provision.

RESOLVED:
The Strategy and Operations Committee **approved** the Medical Appraisal and Revalidation Report and the Safeguarding Annual Report.

WORKFORCE

SO007/21 Workforce Reports

a) Committee AAA Highlight Report

Mrs Brown presented the AAA Highlight report advising that the Workforce Committee had noted three alerts which related to sickness absence, staff turnover and staff retention.

Mrs Brown advised that the Guardian of Safe Working (GOSW) Report had

highlighted the need to engage with the consultants and junior doctors around the importance of Exception Reporting as this would be critical to address rota and scheduling issues.

RESOLVED:
The Strategy and Operations Committee **received** and **noted** the AAA Report from the Workforce Committee.

b) Annual Staff Survey Action Plan

Mrs Royds presented the Annual Staff Survey Action Plan which provided a quarterly update on the progress against the key programmes of work identified in the Trust's Our People Plan and actions from the Staff Survey 2020. It was noted that whilst there had been improvements in Equality, Diversity & Inclusion there was recognition that more work was required to improve the experience of Black, Asian and Minority Ethnic staff. Quality of Care was also an important factor that could be further improved by more positive perceptions of fairness when errors, near misses or incidents happened, giving feedback and taking action.

RESOLVED:
The Strategy and Operations Committee **received** Annual Staff Survey Action Plan Update for assurance

c) Guardian of Safe Working Report

Dr Clark presented the Guardian of Safe Working (GOSW) Report which provided an update on issues related to the Guardian of Safe Working. Dr Clark advised that additional work was required with the trainees around attending trainee doctor forums as well as encouraging the use of DATIX as a way of reporting issues.

It was noted that there had been two non-compliant rota issues raised, one of which related to the Trust currently not delivering a 24 hour Paeds Accident and Emergency service due to staffing issues in the middle grade tier. Dr Clark provided assurance that there was a business case in progress to review this and provide longer term workforce plans to ensure compliance and a substantial workforce.

Dr Clark advised that Ms Gardner, the current Guardian of Safe Working, would be retiring shortly, and the recruitment process was underway to appoint a new candidate.

RESOLVED:
The Strategy and Operations Committee **received** the Guardian of Safe Working Report

d) Freedom to Speak Up Report

Ms Lees presented the Freedom to Speak Up Report which sought to provide assurance regarding staff members' ability to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes were in place for staff to do this safely and confidently, knowing that appropriate action would be taken. It was noted that 17 concerns had been raised during the first quarter of 2021/22 and covered the following themes:

- Staff and patient safety during Covid-19
- Treatment of staff by managers
- Patient experience
- Redeployment
- Racism (staff to staff)
- Staff morale
- Future of vulnerable services
- Behaviours and relationships

It was noted that the National Guardians Office had published new guidance which had included the appointment of a deputy Freedom to Speak Up Guardian.

Ms Lees advised that Rev Abrams would be stepping down as the Freedom to Speak Up Guardian but a replacement had successfully been appointed.

RESOLVED:
The Strategy and Operations Committee **received** the Freedom to Speak Up Report.

FINANCE, OPERATIONS AND INVESTMENT

SO008/21 Finance, Performance and Investment Reports

a) Committee Highlight Report

Mr Clayton presented the AAA Highlight report and highlighted the following three alerts:

- Fluctuating Wave 3 Covid-19 position
- The Trust's ability to only deliver single sex lists was limiting Endoscopy capacity and impacting on waiting times for cancer.
- The Trust had required £0.5m support from the Cheshire and Mersey system in order to breakeven in H1 of 2021-22.

The FP&I Committee had received assurance that, as part of the electrical infrastructure work at the Southport site, the installation of two backup generators had been completed. In addition, the fire compartmentation and alarm work as well as the remediation work to the network and Wi-Fi was progressing.

RESOLVED:
The Strategy and Operations Committee **received and noted** the AAA Highlight Report from the Finance Performance and Investment Committee.

b) Draft Winter Plan

Mrs Neary presented the draft Winter Plan for 2021/22 which included the proposed winter schemes to address the expected increase in demand. She advised that the report had been prepared prior to the receipt of the H2 guidance and as such there was uncertainty regarding if the Trust would receive any additional funds from the national team. An additional paper would be presented at the Strategy and Operations Committee meeting in November for approval.

ACTION
Mrs Neary to present an additional paper at the Strategy and Operations Committee meeting in November for approval **COO**

It was noted that the key driver for the Winter Plan was to reduce bed occupancy and as such the CBUs had played an important role in reviewing deliverability of current schemes as part of the internal planning process. Mrs Neary advised that one of the critical schemes centred around Staff Well-being with the expected outcome of improving staff morale and reducing staff sickness absence.

In response to Ms Bunce's query about the deliverability of the planned discharge lounge scheme for winter 2021/22, Mrs Neary advised that the plans for the scheme were advanced and if the capital bid was approved it could be delivered.

RESOLVED:
The Strategy and Operations Committee **received** the draft Winter Plan

Month 5 Finance Report

Mr McLuckie presented the report which detailed the financial position for August 2021 (month 5) and highlighted that:

- The Trust had delivered services at a £751,000 deficit, following an in-month adverse variance of £496,000.
- The financial run rate had remained broadly consistent prior to month five, with pressures being experienced as a result of slippage against the first half of the year (H1), Cost Improvement Plans (CIP), and the continued temporary staffing costs.
- The planned Elective Recovery Funding (ERF) of £358,000 had reduced to zero per month following changes to ERF income thresholds.
- The Trust was 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 would require external cash support during H2 and had taken steps to secure this for the third quarter.

Mr McLuckie advised that the critical schemes referred to in the draft internal winter plan had been included in the forecast based on the assumption that no additional funding would be received.

Mr Clayton queried if the H2 plans reflected the changes in the CIP planning guidance and Mr McLuckie advised that these had been factored into the plans for the second half of the year.

RESOLVED:
The Strategy and Operations Board **noted** the Month 5 Financial Position

CONCLUDING BUSINESS

SO009/21 Questions from Members of the Public

It was noted that no questions had been received from members of the public.

SO010/21 Message from the Committee

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

SO011/21 Any Other Business

Mrs Stretch extended gratitude to the S&O executive team for the warm welcome that she has received.

Ms Marr advised that she and Mrs Stretch, had met with the Integrated Care System (ICS) leadership to discuss the backlog of maintenance issues across both sites as well as the need to access capital resources in the future.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.58.

The next meeting would be held on **Wednesday 03 November 2021 at 09.30**.

Strategy and Operations Committee Attendance 2021/22												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser							✓					
Ann Marr							✓					
Anne-Marie Stretch							✓					
Gill Brown							✓					
Kate Clark							✓					
Ian Clayton							✓					
Rob Cooper							✓					
Val Davies							✓					
Paul Growney							A					
Nikhil Khashu							✓					
Jeff Kozer							A					
Bridget Lees							✓					
John McLuckie							✓					
Lesley Neary							✓					
Sue Redfern							✓					
Rowan Pritchard Jones							✓					
Christine Walters							✓					
Nicola Bunce							✓					
Sharon Katema							A					
Lisa Knight							A					
Jane Royds							✓					
Nina Russell							✓					
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 27 October 2021

Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO008/21	06-Oct-21	**Finance, Performance and Investement Reports** b) Draft Winter Plan	Mrs Neary to present the updated Winter Plan for 2021/22 in November.	**COO**	03-Nov-21	03-Nov-21	**October update :** An additional paper would be presented at the Strategy and Operations Committee meeting in November for approval. **November Update:** The report was presented at FPI and is referenced in the AAA Committee Report. **Action Completed**	**Green**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**3 November 2021**
Agenda Item	**SO021/21**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK (BAF)**		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

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

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

Recommendations

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

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Sharon Katema, Associate Director of Corporate Governance	Sharon Katema, Associate Director of Corporate Governance

NHS
Southport and Ormskirk Hospital
NHS Trust

BOARD ASSURANCE OVERVIEW (UPDATED 27 October 2021)

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

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

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

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

Inherent Risk			Risk as at 31/05/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	2	4	8

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

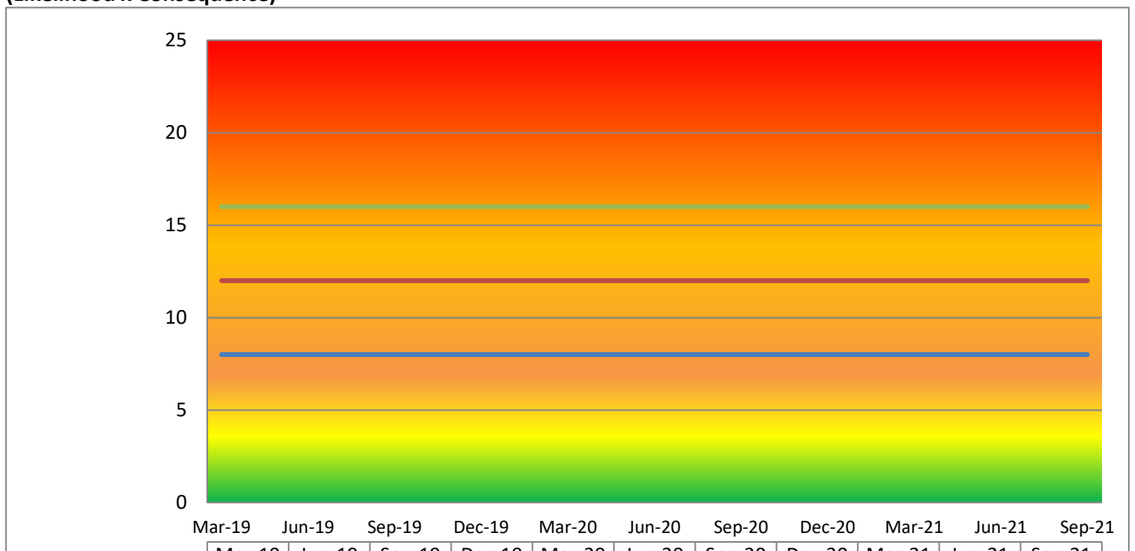
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing four priority areas: • Care of the deteriorating patient; • Care of Older People; • Infection Prevention and Control; • Medicines Management. 4. Risk Management Strategy. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. 12. Training programme (mandatory and non-mandatory). 13. CQC action plan to address areas of underperformance highlighted on inspection. 14. Supervision and education of clinical staff across all professions. 15. Application of Patient Safety and other safety alerts. 16. Patient Safety Specialists appointed. 17. Cycles of business for governance meetings 18. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. 19. Appointment of patient safety specialist 20. Medical examiners roles and fully established programme to review all deaths	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development.	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Health and Safety Group • Risk and Compliance Group 2. Performance, Improvement, Delivery and Assurance (PIDA) with suite of measures. 3. Patient feedback (FFT/Patient Surveys) 4. Clinical audit reports 5. Mortality and SJR Process. 6. Review of documentation and quality indicators through use of perfect ward. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SONASS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits 4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation.	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests and audit. 3. ~~Medical examiners and medical examiner's office not fully established~~.	1. KPI dashboards for wards and CBUs to be reviewed, including visibility at key governance/committee meetings. - **COMPLETE** 2. Cycle of business to be reviewed for Trust-wide and CBU governance meetings. - **COMPLETED reviews and to be implemented** 3. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out – ~~By end March 2021~~ **June-21 Update:** Quality Improvement Plan to be presented to Quality and Safety Committee in June and Board in July-21. 4. Clinical workforce strategy to be completed **– by end of Dec-21.** 5. Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed. – ~~By end March 2021~~ **June-21 Update:** This will be part of the Clinical Workforce Strategy referenced in action 4 and agreed it won't standalone. 6. Risk management training with senior leaders in the organisation **– COMPLETE – ongoing training in place** 7. Complete CQC Must and Should Do actions – ~~By end of Jan 2021.~~ **June-21 Update:** The process of validation and monitoring completion of the actions has been strengthened. Whilst progress has been made, all actions aren't fully complete, some of which have been affected by COVID/other factors. QA Panel being set up to finalise current Trust position before agreeing trajectories for completion. 8. Review KPIs that goes to all governance meetings - **COMPLETE** April-21. All KPIs in IPRs reviewed.

	21. Full roll-out/reporting of Perfect Ward app measures		7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account		9. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. ~~– By end of Jan 2021.~~ **Revised to Sep-21:** The sharing of lessons learnt has been enhanced significantly but further work is planned with Clinical Audit and CBUs to test that completed actions/changes are embedded. ~~10. Unify Fill rates of above 90%. - **COMPLETE**~~
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge				

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

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

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



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

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

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

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

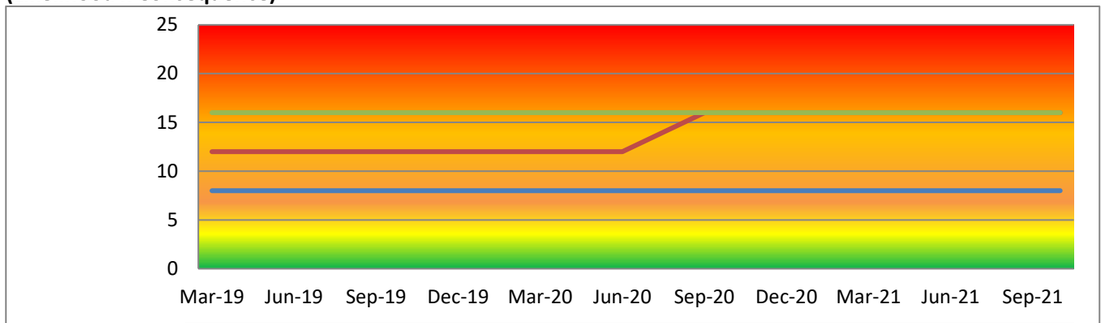
Inherent Risk			Risk as at 15/10/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

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

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it may lead of loss of services **CAUSE** Lack of clear vision for transformation and partnership working in fragile services; inability to recruit in certain medical specialities; year on year rise in demand for urgent and emergency care; capacity and demand; flow through the hospital; system discharge challenges; COVID-19 impact – causing delays in discharge, elective, diagnostic and cancer pathways. **CONSEQUENCE** Delays in the provision of care and treatment resulting in poor patient outcomes and standards of care; over-reliance on temporary workforce leading to increasing prevalence of fragile services; failure of national performance target (cancer, referral to treatment (RTT); failure to reduce delayed transfers of care; failure to deliver NHS constitutional targets; duplication of services with negative impact on CIP; impact on patient experience; intervention by regulator(s)/ commissioner(s);	1. Shaping care together programme. 2. Southport and Ormskirk Admissions and Discharge Working Group. 3. North Mersey A&E Delivery Board. 4. Single accountability framework for reviewing CBU areas for development/strengths. 5. Part of C&M hospital cell group monitoring COVID-19 recovery and sharing capacity where possible. 6. Bronze, silver, gold command structure for oversight and decision making. 7. Weekly Senior Operational Leadership Team (SOLT) meetings 8. Agreed in-hospital winter plan 2020/21. 9. Directorate Manager role that is solely responsible for Access - providing greater strengthen in governance and compliance. 10. Quality impact assessments (QIAs) for all service changes that are considered. 11. Trust policies and procedures updated in line with SITREP requirements / guidance against the constitutional standards. 12. Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. 13. Clinical prioritisation. 14. Access policy for validation of all patients on waiting lists. 15. Use of additional locations to provide treatment where possible. 16. Risk Management Training 17. Agreed out of hospital (system) winter plan 2020/21. 18. System wide capacity and flow meeting held twice weekly to review system discharge delivery. 19. Comprehensive Service Review Programme developed and in progress includes but not limited to fragile services 20. Operational Improvement Group re-established to support standard, consistent	1. The workforce of the Trust does not have the sufficient level of expertise to ensure QI methodology can be applied. 2. Non-standardised Trust approach to quality improvement. 3. Clinical workforce strategy not fully developed. 4. Partnership working not fully established in all fragile services. 5. Insufficient economies of scale to deal with social distancing / workforce impacts arising from COVID-19.	**LEVEL 1** (Operational Management) 1. Operational Performance & Improvement Group (OPIG) oversees work against the four operational priorities: ○ Theatre Utilisation; ○ Patient Flow improvements; ○ Operational productivity; ○ Cancer wait improvements. 2. Risk and Compliance Group. 3. Clinical Effectiveness committee; 4. CBU Governance Meetings. 5. Local IPRs in place to monitor performance which are presented at Performance, Improvement, Delivery and Assurance (PIDA) 6. Performance Manager supporting internal assurance that the Trust complies to SITREP guidance against constitutional standards. 7. Weekly RTT restoration Group meeting in place from March 23rd to review performance against S&O plan 8. Urgent and Emergency Care Programme Board 9. C&M weekly A&E meeting **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. FP&I Committee • Quarterly report to FP&I on progress against each key constitutional standard to offer assurance in actions being taken to maintain and / or improve performance.	1. Not always delivering the 95% standard of all patients presenting to ED being seen, treated and discharged / transferred within 4 hours. 2. During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard. 3. Not consistently delivering the national standard due to workforce challenges across a number of tumour groups in particular Haematology and Head & Neck services.	1. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– ~~By end March 2021~~** June-21 Update: Quality Improvement Plan to be presented to Quality and Safety Committee in June and Board in July-21. Should be monitored through SO1 2. Clinical workforce strategy to be completed **–** ~~by end of March 2021.~~ **Oct 21 Update**: Revised deadline to end of Dec-21. 3. ~~Engage system partners and agree sustainability plans for fragile services – by end of March 2021. June 21 Update - Conclude high level assessment of all services by end June 2021, establish fragile services group – July 21, Identify any further 'red' risk areas by end of July 21~~. **Oct 21 Update: Action Completed with update provided at FPI in September.** 4. ~~Develop~~ Develop sustainable plan to address validation issues in relation to the non-RTT tracker. **– ~~Action on track for completion:~~** ~~Plan and Business Case approved at Board and approach endorsed by NHSE/I.~~ ~~AfC approval not completed substantive recruitment outstanding~~. **~~June 21 Update:~~** ~~Completed 5 x WTE in post and the work on Non RTT tracking has begun. Trajectory set for 3 months.~~ **Oct 21 Update:** Ongoing review 25000 validations completed in 3 months as per agreement with CCG. Analysis of outcome and themes underway 5. ~~Use of Resources Group is now established first meeting to be held 29 March with DoF Chair Update: Revised purpose, ToR and membership under~~

	reputational damage; loss of public confidence.	and measurable PMO approach to service improvement 21. Fragile service programme in place; includes development of options and ongoing monitoring of progress 22. Use of Resources Programme established to support well led approach for clinical and corporate services. 23. Established Gold Command of the day to ensure flow and clear escalation 24. Frequency of Gold/Silver meetings revised based upon trigger alerts linked to COVID-19 admissions. 25. RTT restoration plan being monitored on a weekly basis and reported to gold/ETM weekly. 26. Non RTT trackers now in place with planned programme of work 27. Daily COVID escalation meeting 28. Clinical review of all admission the day before admission date, type of bed & plan identified		• monthly reports on elective restoration, Urgent and Emergency Care and COVID report 3. OPIG key metrics agreed to ensure integrated PMO approach **LEVEL 3** (Independent/Semi-Independent) 1. NHSI Single Oversight framework 2. CQC 3. Reports to CCG quality and performance meetings. 4. NHS benchmarking data including Model Hospital Dashboard 5. Getting it right first time (GIRFT) programme. 6. Cancer alliance oversee delivery and performance regarding cancer metrics. 7. Internal Audit and External Audit reports 8. Peer review boards 9. Urgent and Emergency System Board 10. Dr Foster reporting 11. Integrated QIPP reporting with CCGs 12. Weekly NHSE Elective Restoration and NHSE urgent and emergency care meetings. 13. Weekly C&M A&E meeting		~~review by DoF – expected end Jul 21.~~ **Action Completed.** 6. Business planning process in place, 'lite' in Q4 2020/21 full review due in Q1 2021/22 following national guidance **Jun 21 Update** – plans set for H1 21/22 and planning guidance for H2 received and plan being submitted as required. 7. PMO alignment to CBUs to support standardisation of approach, independent reporting and QI approach. **Jun 21 Update**: **Completed**
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

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

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

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

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

Inherent Risk			Risk as at 15/10/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	3	4	12

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

Risks to objective

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

CAUSE
Fluctuating income and activity; Inability to deliver the required levels of CIP; inability to control agency costs and premium payments to support fragile services; insufficient liquid cash to meet expenditure obligations on a monthly basis; capital cost estimations are higher than originally predicted.

CONSEQUENCE
Shortfall in funding (PSF/FRF); reductions in services or the level of service provision in some areas; potential loss in market share; regulatory intervention; lack of financial stability; missed opportunities to invest in services and new technologies; failure to deliver the capital programme.

Controls

1. Financial Systems and processes.
2. Scheme of Reservation and delegation
3. Standing financial instructions
4. Budget holder training.
5. Short term financial plan for the Trust.
6. Cheshire and Mersey Health Care Partnership (HCP) 5 year plan
7. Business Development and Investment Group (BDIG) approves all business cases and reports to FP&I Committee.
8. Capital Investment Group
9. Strategy Task and Finish Group
10. Shaping care together programme
11. Health Trust Europe (HTE) Procurement Framework
12. Cheshire and Mersey Framework
13. National Agency Team Support
14. People Activity Group (PAG)
15. 2020/21 Cost improvement (CIP) programme commenced and indicative plan for 2021/22.
    CIP targets have been shared with CBUs and Corporate functions
16. Smart sheet software from PMO.
17. e-Rostering
18. Financial Management Framework
19. Use of Resources Action Plan in place.
20. Implementation of strategy for the roll out of patient level costing to inform clinical understanding of cost drivers
21. Individual Efficiency Groups established across CBUs and Corporate Services.

Gaps in Controls

1. Due to COVID-19 unable to accurately forecast the Trust's income. The temporary arrangements for 2020/21 will eventually come to an end but there is no clarity on the future of the Payment by Results (PbR) tariff.
2. Currently no financial recovery plan that delivers break-even/ services the underlying deficit.
3. Lack of three year medium term financial model, taking into account current position and savings from any reconfiguration in line with Sefton Transformation Board Strategy.
4. E-rostering system not fully utilised across the Trust.

Sources of Assurances

LEVEL 1
(Operational Management)

1. Performance, Improvement, Delivery and Assurance (PIDA) Boards.
2. Model Hospital Group
3. Trust Board
4. Reports from the Corporate and CBU Efficiency Programme Group (EPG) meetings to Use of Resources Group
5. Monthly CIP review meetings
6. Monthly cash flow forecast

LEVEL 2
(Reports and Metrics monitored at assurance committees and/or Board)

1. Integrated Performance Report (IPR)
2. Monthly financial position reports to HMB, FP&I Committee and Board
3. Activity and performance reports
4. Reports to FPI from the Use of Resources Group

LEVEL 3
(Independent/Semi-Independent)

1. NHS England/Improvement
2. CQC
3. CCG
4. Internal Audit reports
5. External Audit reports
6. Model Hospital
7. Costing returns
8. National Agency Team reports

Gaps in Assurance

1. Inability to monitor trajectory against financial recovery plan until developed.
2. Robust tracking of CIP programme.
3. High level forecasting is a manual driven process.

Mitigating Actions/Progress

1. Develop scenario-based approach to business plan/budget setting for 2021/22 taking account of the COVID-19 trajectory and emerging financial arrangements for 2021/22 – ~~by end of March 2021~~. **June 21 Update**: Delayed due to COVID, further discussions taken place with SBS, IT issues need resolving – by end March 2022.
2. Develop financial framework to underpin Shaping Care Together programme, setting out affordability and potential financial improvement/recovery ~~– by end of March 2021. **June 2021 Update**: Revised target date to September 2021.~~
   Review underlying deficit and drivers by **November 2021**
3. Develop reporting mechanism to track progress with financial improvement recovery plan – ~~by end of March 2021.~~ ~~**June 2021 Update:** Revised to September 2021~~.
   Oct 21 Update: Revise financial reporting format to be more issues, risk and action focused **November 2021**
4. Internal audit review of CIP programme **–** ~~by end of March 2021.~~
   Revised to Q3 2021/22: to fit in with the embedding of the new actions included. October Update: Reported at Audit in October.
5. Establish process for identifying, implementing and monitoring delivery of efficiency/productivity (CIP) **–** ~~by end of February 2021. **June 2021 Update:** New additions to Executive Team currently reviewing process – by end July 2021~~.
   October Update: Review completed and TOR for Use of Resources agreed. Individual Efficiency Groups now established for each CBU and corporate services. Output from them is fed into the use of resources group and then onto fp&i. **Action Complete.**
6. ~~Implement and~~ report progress against the Use of Resources action plan **– report to FP&I Committee by end of March 2021.**
   ~~**June 2021 Update**: Reviewing Use of Resources workplan – **by end of July 2021.**~~
   October Update: Need to update to take account of long term collaboration agreement

					7. E-rostering to be fully rolled out in all areas – ~~by end of March 2021~~. **~~June 2021 Update:~~** ~~Revised target date to September 2021.~~ **October 2021 Update**: Rostering management to be centralised Jan 2022 8. NHS Shared Business Services developing a new forecasting and budgeting tool – ~~to be tested by end March 2021 with aim to use in 21-22 financial year.~~ See 1 above

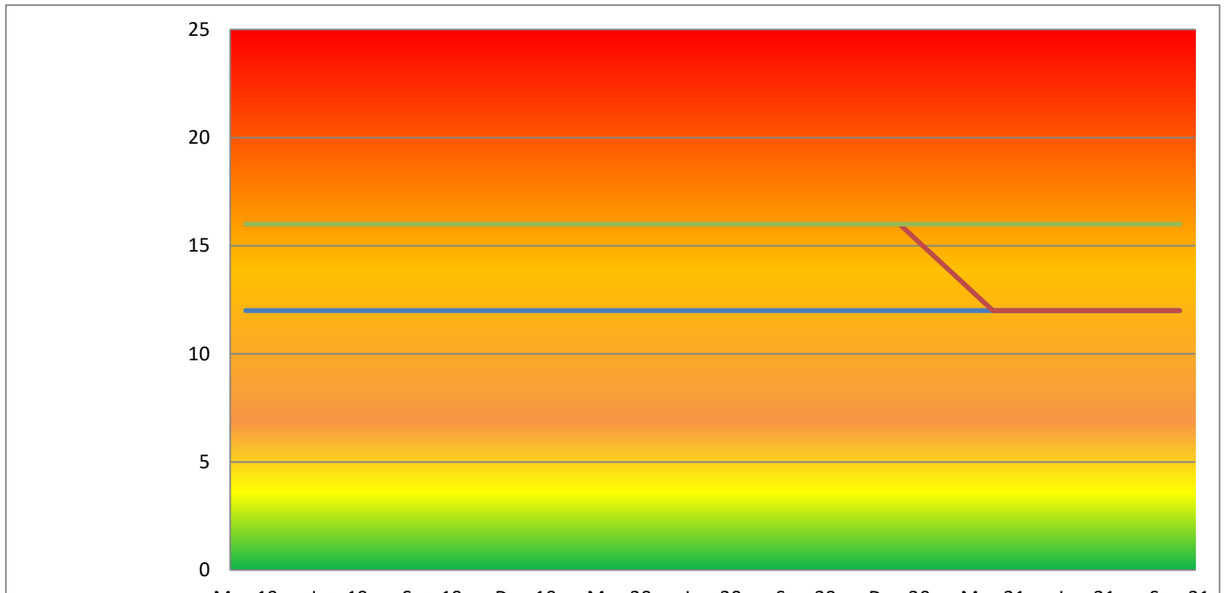
The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

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

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

RISK TRACKING

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



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

Linked Risks: 2

1942: Eradicating Trust deficit by 2023/24

1688: Anaesthetic staffing

Comments

Update – October 2021

- The strategic risk and associated linked risks have been reviewed and this remains a high risk.
- Since the BAF was last updated, one action has been completed, one aligned with another action and three actions have seen the target date revised.
- The controls and actions have been reviewed in line with Interim Report on Controls and Assurances which was presented at Audit Committee in January 21.
- It's anticipated the completion of the remaining BAF actions will further enhance the controls and assurances with the aim of reducing the risk to achievement of the strategic objectives.

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated			Assurance Committee: Workforce Committee Executive Lead: Director of HR and OD
RISK ID	**4**	**Risk Description**	**If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience**

Inherent Risk			Risk as at 25/10/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	**12**	3	4	**12**	2	4	**8**

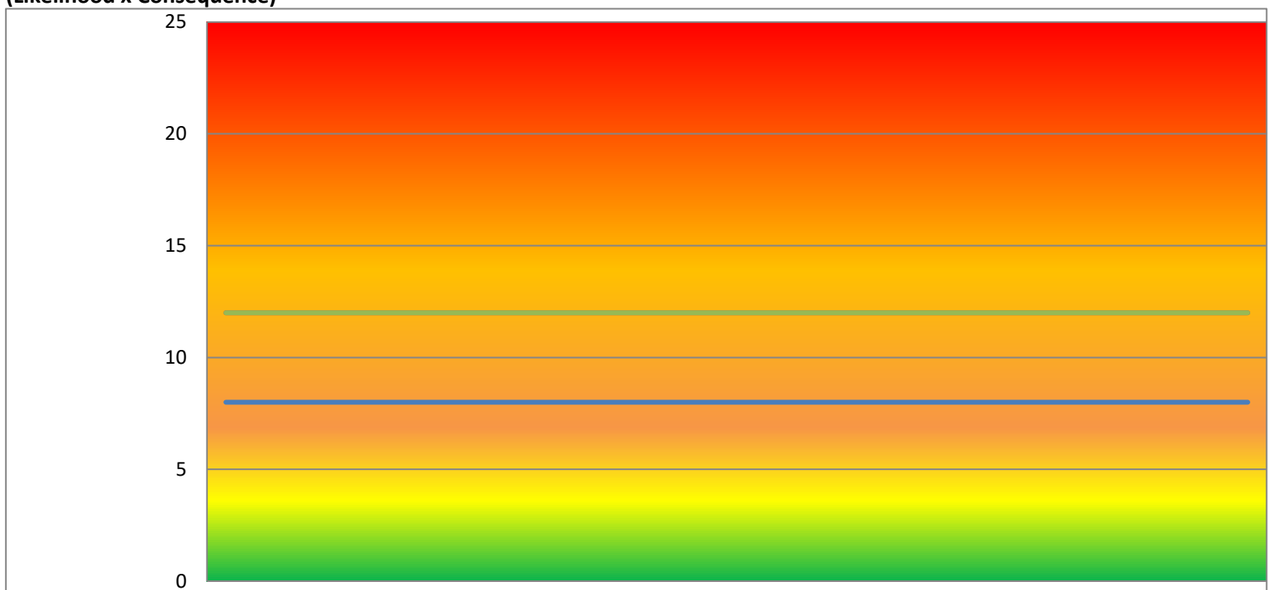
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Our Resourcing Plan (Strategy supported by clinical workforce plan). 3. Inclusive recruitment and selection processes in place 4. Overseas Recruitment Campaign for Nurses 5. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 6. Job plans for medical staff. 7. Corporate staff induction 8. Quality PDR process and career development discussion 9. Flexible working options in place including team rostering 10. Ward/departments non-medical staffing position is controlled through: 11. 3 x daily at staffing huddle; 12. 7 day staffing matron in place for oversight and management; 13. Weekly staffing review and sign off; 14. Roster sign off meeting. 15. People Activity Group (PAG) with oversight of business cases for additional staffing 16. Leadership development programme available to staff 17. Effective approach to supporting attendance to reduce sickness absence levels. 18. Updated Resourcing Plan required and no clinical workforce plan in place 19. Lead Employer progression 20. Trust Warm Welcome induction programme	1. Low number of applicants from BAME backgrounds successful at interview 2. In need of earlier identification of junior doctor rota gaps and proactive block booking to address. 3. Alignment of job planning rounds to business planning cycle 4. No physical induction or viable alternative in place during pandemic 5. Poor PDR compliance rate 6. E-rostering system not fully utilised across the Trust and limited options for flexible working 7. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion; 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Staff Survey & Quarterly Staff FFT/Survey 9. GMC Medical Staff survey – annual 10. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG	1. Sickness absence above target 2. Low compliance rates for PDR completion 3. High nursing vacancy rates 4. A number of medical vacancies have been vacant for a long time	~~1.~~ Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed. Aiming for this to be in place by the **end of December 2021**. 2. Engagement planned with staff networks to review Recruitment and Selection process to identify improvements, enhancements and positive action approaches. **Date to be arranged before September 2021.** Involve the International Nurse cohort to act as a pilot for developing support to aid career development at the Trust. **Terms of reference to be agreed by August 2021. Update Ongoing – expected completion date December 2021** 3. Alignment of business planning to Job Planning Round 2021. **2021 Round still in progress. Ongoing** 4. E-rostering system now being rolled out to remaining departments (**target completion date September 2021**); departments identified as pilots for team/self-rostering is now underway – **evaluation timescale yet to be agreed**; agile working group developing principles for hybrid working and review of flexible working policy to be piloted with CMO staff in **July 2021. Ongoing and expected for completion in September 2021.** 5. Review of supporting attendance policy to commence and support being access from NHS England/Improvement to address areas identified as outliers compared to Trust's with lower absences. Further meeting to take place with NHSE/I **w/c 12th July 2021**. Been reviewed and targeted date for completion of review December 2021. 6. Each CBU has developed an improvement trajectory showing planned reduction in sickness absence over next 3 months and progress to be monitored through monthly

				4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		PIDA **from April 2021. Expected to continue throughout the winter period.** 7. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust – **aim to appoint by September 2021. Updated – extended to December 2021**
The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge						

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

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

RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce	**Update – September 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • A full review of the controls and assurances has been undertaken, recognising the shift in focus following the implementation of the Trust's Our People Plan. The actions have also been reviewed to address the gaps identified. • Since the last review, three actions have been completed and are included in the Controls. • Since the actions were developing, there have been some aggravating factors which have come to play such as the impact of Covid, high unprecedented demand on services and increased vulnerability of Fragile Services. Whilst there has been notable progress, the actions which have been identified have not been sufficient to warrant the review of the risk. Thus, the risk rating remains unchanged.



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

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

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

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

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

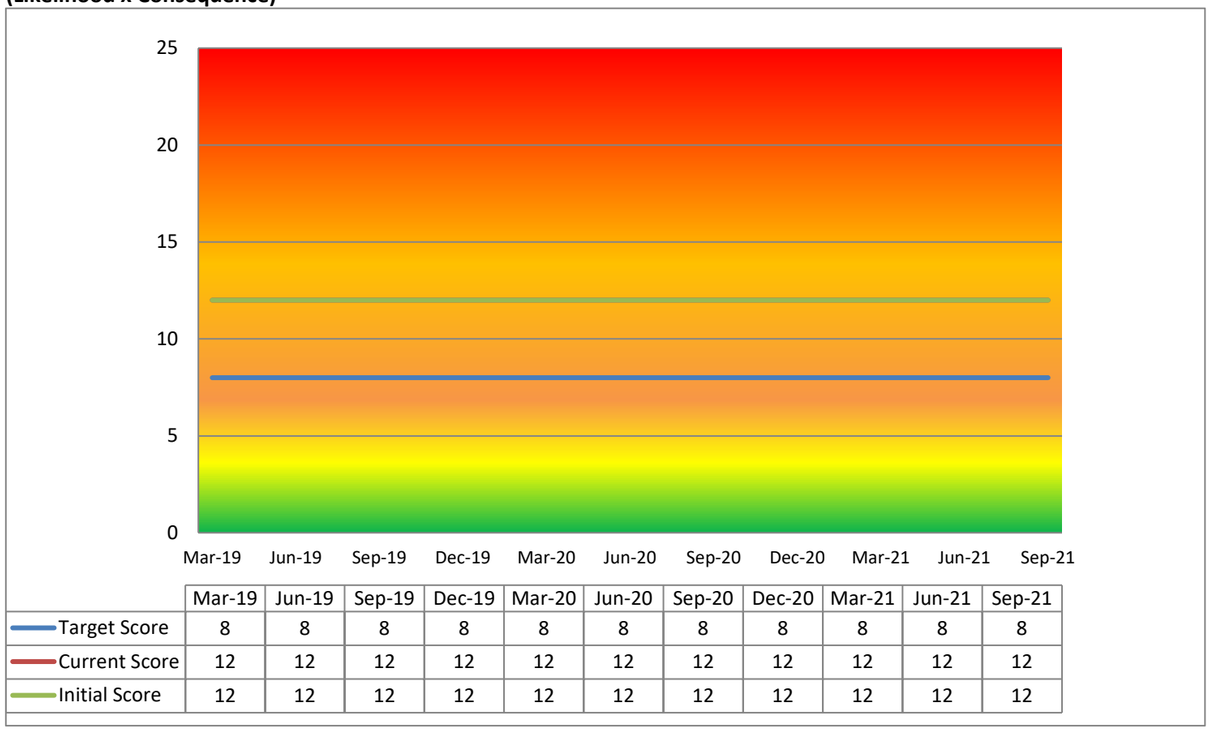
Inherent Risk			Risk as at 21/09/2021			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours; leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Trust Values & Behaviours Framework 3. Trust values and behaviours embedded in the employee life cycle 4. Our Equality, Diversity and Inclusion Plan in place to deliver Trust's mission and objectives 5. Equality, diversity and inclusion networks in place 6. Just and learning principles embedded at the Trust, particularly in processes for raising/investigating concerns and lessons learned 7. Freedom to speak up guardian 8. Joint negotiating committee (JNC) 9. Staff Stories presented to Workforce Committee 10. Team development support available to promote positive relationships 11. Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available 12. Mandatory and role specific training programme in place 13. Quality PDR discussions to promote positive behaviours 14. Talent management framework 15. Apprenticeship programmes leadership & management offer Levels 3-7 16. Board role modelling and visibility through: a. Back to the floor sessions; b. 15 steps walkabouts in wards/departments 17. Board Development sessions planned throughout the year 18. Work stream established as part of Valuing Our People Inclusion Group focussed on embedding the Trust's Values and Behaviours. 19. Staff communication and engagement plan 20. embedding Values and Behaviours in Induction and PDR processes. 21. Refreshed and introduced groups within the structure to support delivery of Our People Plan	1. Awareness of Trust Values and Behaviour framework 2. Limited alignment of values to key stages in employee life cycle 3. Up to date EDI mission and objectives required 4. Low participation in staff networks 5. Limited awareness of Just and Learning Culture and alignment to processes for looking into incidents/lessons learned 6. Team development interventions are currently expensive and resource intensive 7. No talent management/succession planning frameworks in place 8. Low visibility of leadership team reported in recent Staff Survey 9. Pause of Board Development sessions due to COVID-19. 10. Schwartz round facilitators	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. 11. Valuing our people report **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training; ○ PDR completion; ○ Sickness rates. 2. Turnover; 3. Vacancies; 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG	1. Staff Survey Engagement score has improved in year and but remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address relatively poor engagement with equality, diversity and inclusion networks. 4. High number of employee relations cases and concerns raised through Freedom to Speak Up linked to negative interactions and relationship issues	1. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. Starting with an externally facilitated session with Board **on 7th July 2021**, to help shape Trust's EDI Mission and Objectives. **Update - Currently under review.** 2. 6 Schwartz Round facilitator regional training places secured and HR Business Partners to be upskilled to support team development intervention by **September 2021**. Update – now in implementation phase with an expected start date of **October 2021**. 3. Awaiting launch of national talent management/succession planning framework to apply at the Trust. **Update**: The Trust is adopting the Leadership Academy system, leadership competency framework and will undertake a self-assessment with leaders through a programme of work overseeing by the workforce Improvement group. Targeted completion date: End of Q4 4. Back to Floor sessions reinstated for Board members; 11 Wellbeing Guardians assigned to hotspot ward areas; Ward Buddy initiative to be launched **in July 2021** assigning Wards to Directors and Deputies; increased presence of Executive Team at Ormskirk (permanent office base identified) 5. Work programmes identified by the Valuing Our People Inclusion group from feedback from staff survey to improve staff engagement score. Quarterly Staff Survey to be **launched on 1st July** and support regularly monitoring of impact of the VOPIG programme of work. 6. Increased engagement with the regional mediation service to assist in the informal resolution of relationship issues. Progress to be reviewed at VOPIG in **December 2021.**

		• Valuing Our People Inclusion Group • Just and Learning Culture Group 22. At our Best leadership programme 23. Medical Leadership programme 24. PDR Improvement Plan monitored though PIDA and the valuing our people inclusion.		4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**  	**None**	**Update – September 2021** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • A full review of the controls and assurances has been undertaken, recognising the shift in focus following the implementation of the Trust's Our People Plan. The actions have also been reviewed to address the gaps identified. • The reinstatement of Valuing Our People through Inclusion Group continues to ensure progress against a large number of these actions and will also provide some accountability through the introducing a mechanism for staff to share their lived experiences, challenge progress of the priorities identified and shape further actions to drive improvement and enhance culture. • Since the BAF was last presented, 7 actions have been completed. However, the Risk rating remains unchanged due to the ongoing challenge with Covid 19 and focus on Fragile Services have had an impact on the participation by leaders in development programmes and staff in engagement activities.

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

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

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Assurance Committee:** Trust Board **Executive Lead:** Chief Executive

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

Inherent Risk			**Risk as at 15/10/2021**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	5	**15**	3	5	**15**	3	3	**9**

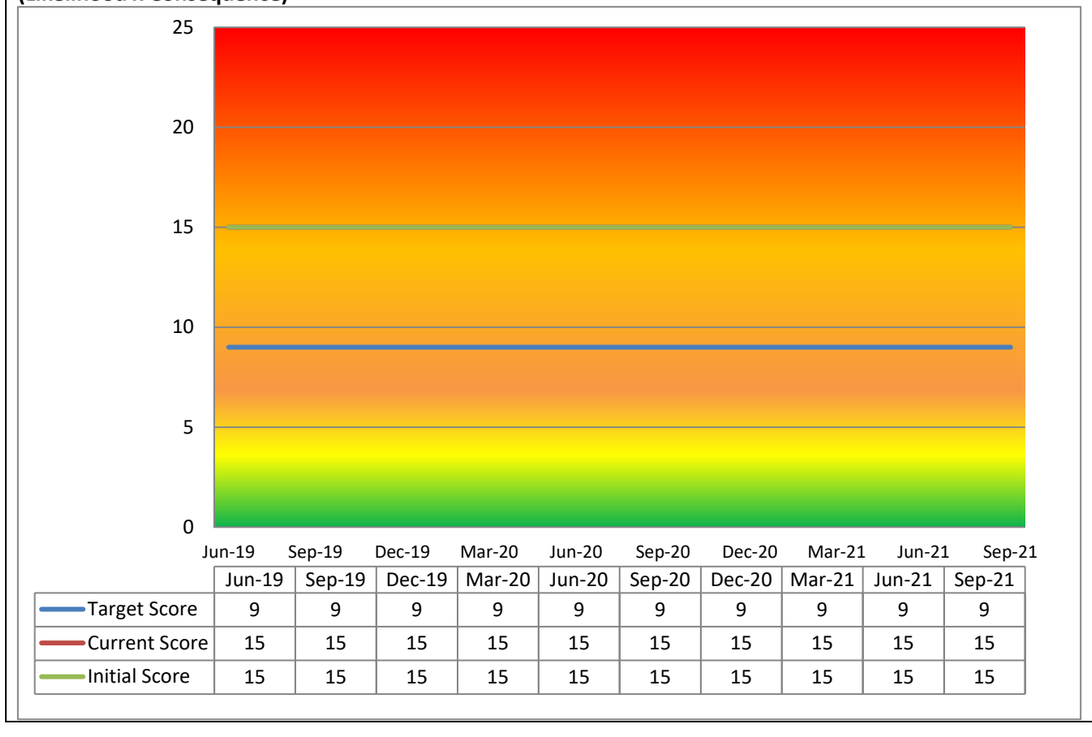
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services **CAUSE** Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire; lack of system-wide workforce planning to address the issues around qualified staff pipeline over the next 5 years and current speciality specific emerging workforce gaps; lack of Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach; challenges around working across two ICS/STP footprints; lack of clarity about additional capital funding support at CMHCP/NHSE/I level to enable emerging scenarios to address sustainability challenges; lack of public engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** Clinical unsustainability due to current and projected workforce gaps as well as activity outweighing capacity; financial unsustainability due to costs significantly outweighing income; poor estate utilisation due to inability to fully reconfigure services; unsustainability of a	1. Robust system governance in place, including: ○ Southport, Formby & West Lancs Programme Board: Shaping Care Together ○ Shaping Care Together operational groups: Delivery Group and Communication & Engagement Group ○ Southport, Formby & West Lancashire Clinical Leaders Group ○ Sefton Provider Alliance 2. Robust internal governance in place, including: ○ Hospital Improvement Board (HIB) - leading Vision 2020 and Single Improvement Plan 3. Southport and Ormskirk Improvement Board (SOIB) - leading Vision 2023 4. Documentation in place: ○ Finalised and agreed Shaping Care Together (SCT) programme plan for delivery ○ KPMG Case for Change ○ Sefton 2gether ○ West Lancs Building for the Future ○ Acute Sustainability Vision and Design Principles ○ Cheshire and Mersey sustainability and transformation partnership (STP) plan. 5. Whole system engagement from health, social care, voluntary, community and faith sectors (VCFS) partners to be able to address whole system change.	1. Clear alignment between Shaping Care Together programme and System Management Board. 2. Lack of established Patient & Public Reference Group.	**LEVEL 1** (Operational Management) 1. Trust Board 2. Finance, Performance and Investment Committee. 3. Quality and Safety Committee 4. Workforce Committee 5. Risk and Compliance Group 6. Clinical Effectiveness Committee 7. Vision 2020 agreed at Board, updated version now in development 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. Ongoing review and management of 'fragile services'. 10. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board. 11. Patient and public engagement strategy monitored at Programme Board. 12. Equality Impact Assessment outcomes monitored at programme board. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. CEO's reports to Board 2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments 3. Single Improvement Plan reports to Improvement Board 4. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group **LEVEL 3** (Independent/Semi-Independent) 1. Southport, Formby & West Lancashire Joint Committee		1. Reporting of progress monthly internally to Trust Board via HMB, and externally to SOIB. **– COMPLETE and ongoing** 2. Establish reporting line into the newly set up CMHCP/NHSEI Oversight Group **– Action complete and ongoing** 3. Develop, implement, embed and review Communication and Engagement Strategy and Plan with an effective patient and public forum. **– Action complete and ongoing:** Stakeholder Advisory Group in development 4. Production of an agreed SCT Programme Plan to include key milestones to enable public consultation - **Action complete:** Roadmap and full programme plan through to implementation (2025+) complete and monitored through programme governance 5. Southport, Formby & West Lancashire Clinical Strategy development aligned with organisational strategic directions and emerging solutions from the engagement work to be complete by end of August 2021. **Update:** Second round of Models of Care Workshop completed to test out the clinical case for change, further workshops booked in June and new ways to collaborate online being developed 6. Strategic Partnership criteria, principles and framework to be developed in line with engagement approach to ensure transparent and robust partnerships developments that may be required to address sustainability challenges ~~to be complete by end of December 2020. Revised to end of May 21~~ **–Revised to end June 21** revised engagement plan has extended the listening phase 7. System wide Equality, Health Inequality and Quality Assurance process to be established **– Action Complete:** Equality Impact Assessment process established. Health Inequalities assessment in progress. Travel impact assessment

	standalone organisation to continue to deliver acute services for the population; potential impact on neighbouring organisations and services if core acute services can no longer be delivered by the Trust.	6. Quality and equality impact assessments completed and reviewed before any changes to Trust service provision. 7. System Equality Impact Assessment process established.		2. Southport & Ormskirk Improvement Board - meets monthly. 3. Cheshire & Mersey Health & Care Partnership (CMHCP): Strategic Oversight Group (reporting line) 4. Sefton Provider Alliance. 5. West Lancashire Multi-speciality community partnership (MCP). 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. CCGs 10. Internal Audit 11. External Audit.		expertise secured, System Quality Impact Assessment in development with CCC. 8. Programme to be monitored internally through Trust Board **– Action complete and ongoing** 9. Establish Finance and Capital Assurance Group with alignment to the System Management Board **– Update** FCA group established with work near completion on the drivers of deficit. Key risk to progress around the imminent retirement of 3 senior financial leads across the CCG and Trust – DoFs have met and agreed mitigation approach
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve

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

RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 3 x5 = 15 Current 3 x 5 = 15 Target 3 x 3 =9 **(Likelihood x Consequence)**	**1942:** Eradicating Trust deficit by 2023/24 **2072**: Failure to achieve 2019/20 financial control total **1688**: Anaesthetic staffing	**Update – October 2021** • The strategic risk and associated linked risks have been reviewed and this remains a high risk. • It's anticipated the completion of the remaining actions for 2020/21 will further enhance the controls with the aim of reducing the risk to achievement of the strategic objective. • Public engagement continues with a refreshed microsite and simpler questionnaire. First stage of listening is due for completion in June.



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

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO023/21**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Management Team (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance & Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Trust's performance against key national and local priorities.

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 21/22 SOF and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator has a Statistical Process Control (SPC) chart and commentary. Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

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

Recommendation

The Committee is asked **to receive** the Integrated Performance Report detailing Trust performance in September.

Previously Considered By:

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

Strategic Objectives

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

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

Trust Board - Integrated Performance Report

Performance Summary

The Trust Integrated Performance Report covers 4 areas aligned to Trust Strategic Objectives as follows;

Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

Operations - **S02** – *Deliver services that meet NHS Constitutional Standards and regulatory standards*

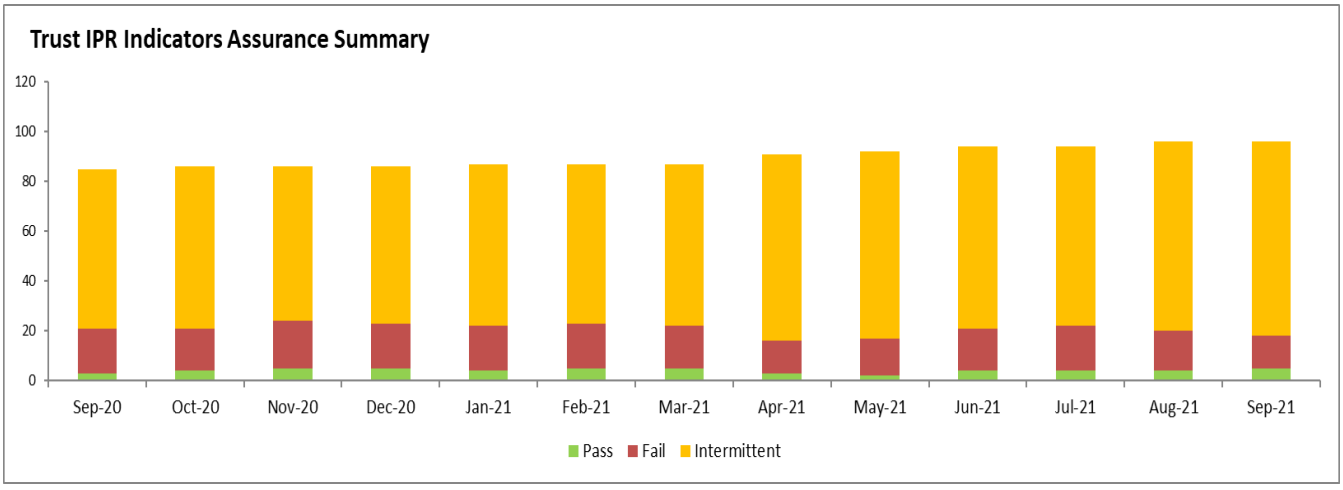
Finance - **S03** – *Efficiently and productively provide care within agreed financial limits.*

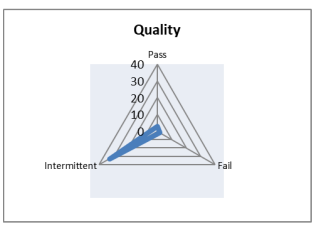
Workforce - **S04** – *Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated* and **S05** – *Enable all staff to be patient-centred leaders building an open and honest culture and the delivery of the Trust values.*

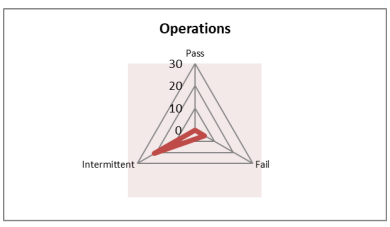
The majority of indicators in this month's IPR are still classed as intermittent. Only Care Hours Per Patient Day, HSMR, Friends and Family Test - Patients - % Response Rate, Mandatory Training and the Sickness Rate – Medical are classed as fully assured.

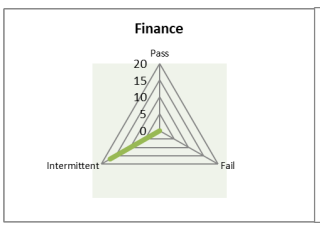
The following AAA will highlight any specific areas to the Board which they should be alerted, advised, or assured. These indicators have previously been presented to the Trust's three assurance committees.

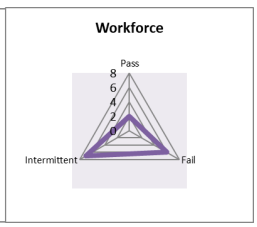
	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Pass	3	4	5	5	4	5	5	3	2	4	4	4	5
Fail	18	17	19	18	18	18	17	13	15	17	18	16	13
Intermittent	64	65	62	63	65	64	65	75	75	73	72	76	78











Southport and Ormskirk Hospital NHS Trust

ALERT

Quality: Metrics to be alerted to this month include the % of deaths screened, which remains low at 10.4% in August.
Safe Staffing failed to achieve the 90% target for the last three months. This has been impacted by high sickness rates amongst both Registered and Un-Registered Nurses.
The Trust has reported the highest number of Delivering Same Sex Accommodation breaches since February 2020 due to breaches reported from the Clinical Decision Unit, impacted by patient flow challenges in month.
The Friends and Family Test - % That Would Recommend remains below target and has declined marginally in month. There continues to be a focus on addressing areas with low response rates and low recommend rates.

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 and at 35.7% is the highest proportion of patients waiting longer than 6 weeks since June 2020 although there is an improving position emerging in October. Cancer 14-day performance continues to be impacted by Endoscopy and outpatient capacity. Delays in diagnostic investigations are also impacting the 62-day cancer target. The RTT waiting list continued to grow and stands at 12,929 in September.
CIP targets/financial trajectories continue to be a challenge across all CBU's and have been raised as an alert in each CBU's monthly PIDA meeting.

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 three consecutive months. Sickness rates for Registered and Un-Registered Nursing remain high at 8.2% and 9.9% respectively although this is lower than the previous month. There are sickness hotspots evident within Medicine and Emergency Care CBU. Planned Care CBU raised an alert regarding Ophthalmology Medical staffing.

ADVISE

Quality: To advise the Committee, within the Maternity section, the Percentage of Women booked by 12 weeks and 6 days has failed to achieve target in September, but maternal reasons are the main contributing factor. Both the Caesarean and Induction rates have increased in September although remain statistically within expected levels.
Although not statistically significant, infection rates for C.diff, E. Coli, Klebsiella and Pseudomonas are in excess of the targets.

Finance & Operations: Stroke performance remains below target at 65.5% although the Committee should be assured that no harms have been caused. Analysis into the breaches for April – August has been undertaken to enable a focus on improvement.
Whilst the number of ambulances waiting over 30mins has increased, the Trust remains in the upper quartile across Cheshire & Mersey.
Overall elective inpatient activity is significantly above plan at 114% against a national target of 95% of 2019/20 levels.
35% of 52 week waiters have TCI's.
Haematology has re-opened to referrals with effect from early October.

Workforce: This month's advisory notices include the position for Personal Development Reviews, which continues to rise and at 79.5% is the highest level for more than two years.

The Medical Vacancy rate has increased in September, but this has been impacted by the reporting of the TUPE of Haematology doctors.

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 73.2 continues an excellent trend with no diagnosis level SMR's exceeding 100 this month. Also within the Mortality section, the SHMI has dropped below 100 for the first time since December 2019. 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.
Breastfeeding initiation remains ahead of target.

Finance & Operations: 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.

Workforce: Metrics which can provide assurance to the Committee include the Mandatory Training rate, which remains above target, reporting 88% in September.
The Time to recruit for Medical Staff has reduced in September and is well below the target.

Activity Summary – September 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	September 2019	September 2020	August 2021	September 2021	Trend
Overall Trust A&E attendances	10,429	8,774	9,403	9,920	▲
SDGH A&E Attendances	4,795	4,317	5,305	5,099	▲
ODGH A&E Attendances	2,480	1,650	1,970	2,562	▲
SDGH Full Admissions Actual	1,129	1,544	1,192	1,110	▼
Stranded Patients AVG	167	143	156	169	▲
Super Stranded Patients AVG	64	42	44	59	▲
MOFD Avg Patients Per Day	64	40	43	42	▲
GP Referrals (*Exc. 2WW*)	2,321	2,001	1,973	1,662	▼
2 Week Wait Referrals	763	785	870	937	↻
Elective Admissions	180	150	143	220	↻
Elective Patients Avg. Per Day	6	5	5	7	▲

Activity Summary –September 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	September 2019	September 2020	August 2021	September 2021	Trend
Elective Cancellations	20	20	61	70	▲
Day case Admissions	1,953	1,371	1,203	1,363	▼
Day Case Patients Avg. Per Day	65	46	39	45	▼
Day Case Cancellations	51	19	89	83	▲
Total Cancellations (EL & Day Case)	71	39	150	153	▲
Total Cancellations (On or after day of admission, non clinical reasons)	4	0	1	4	▲
Outpatients Seen	22,945	20,816	18,939	21,005	▲
Outpatients Avg. Per Day	765	694	611	700	▲
Outpatients Cancellations	4,237	4,117	3,960	4,474	▲
Theatre Cases	620	360	624	478	▲
General & Acute Beds Avg. Per Day	411	419	403	400	▼
Escalation Beds Avg. Per Day	2	0	0	0	
In Hospital Deaths	63	56	77	74	▲

NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report

Board Report

September 2021

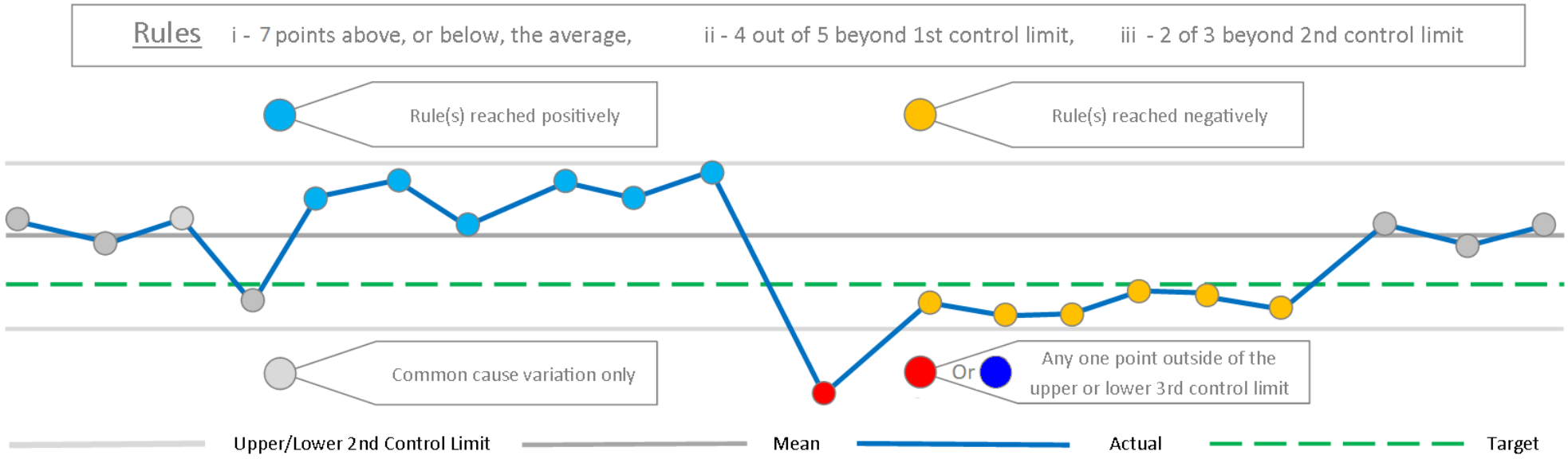
Guide to Statistical Process Control

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

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

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

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



Executive Summary

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Mortality	1	1	2	1	1	0	1	1
	Patient Experience	1	1	6	0	2	3	0	3
	Infection Prevention and Control	0	0	4	1	0	0	0	3
	Harm Free	0	1	10	0	0	1	1	9
	Maternity	0	0	11	1	1	1	0	8
Operations	Cancer	0	0	3	0	2	1	0	0
	Access	4	0	9	7	1	0	1	4
	Productivity	1	0	9	1	0	3	3	3
Finance	Finance	0	0	17	2	0	1	5	9
Workforce	Organisational Development	1	1	1	0	0	2	0	1
	Sickness, Vacancy and Turnover	5	1	6	3	0	0	2	7

Assurance

Measures the likelyhood 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). Indicators showing special cause improvement are WHO Checklist and Hospital Acquired Category 2 Pressure Ulcers. Although not statistically significant, Safe Staffing has failed to achieve the 90% target for the third consecutive month with a resulting impact on the Care Hours per Patient Day which has declined in month.

Operational Narrative:

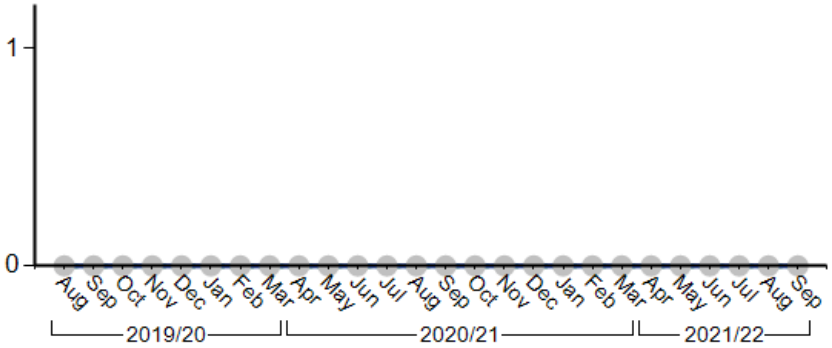
Staffing - Monitoring of staffing still occurs twice daily with a view to ensuring fill rates are acceptable and patient safety. Issues remain reflective of the ongoing pandemic where staffing shortages due to isolation and sickness remain. Acuity of patients continues to impact on staffing requirements, and we have increased the availability of “allocate on arrival” shifts through NHSP to support not only shortfall but wards with high acuity of patients. 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 twice daily basis. Weekly staffing summits convened to review staffing in weeks/months ahead to provide reassurance and planning. International nurse recruitment continues with high levels of success and local recruitment events have bolstered staff numbers.

Pressure Ulcers – the number of both category 2 and category 3 Hospital Acquired Pressure Ulcers has reduced in September. Four outstanding reviews into the category 3 HAPU’s reported in August were completed in September. One has identified lapses in care in relation to documentation, with lessons learnt including completion of body maps, care plans, care and comfort charts, Skin Bundles and ensuring the Nurse in charge of providing care to the patient documents the pressure prevention care required at the start of each shift. Additionally, all patients at risk are discussed as part of the ward safety huddle each shift and all any referrals are escalated in a timely manner. Quality Improvement projects identified to support improved risk assessment compliance and body map from admission (Admission SWARM project for AMU) and Pressure Ulcer Reduction Project are in place. Two August incidents were downgraded to low harm as they resolved with minor treatment and the fourth is awaiting confirmation that it was a hospital acquired case. Three category 3 HAPU’s have been reported in September, one has been deemed unavoidable due to the patient’s clinical condition, the remaining two are currently being investigated through the Harm Free Care process.

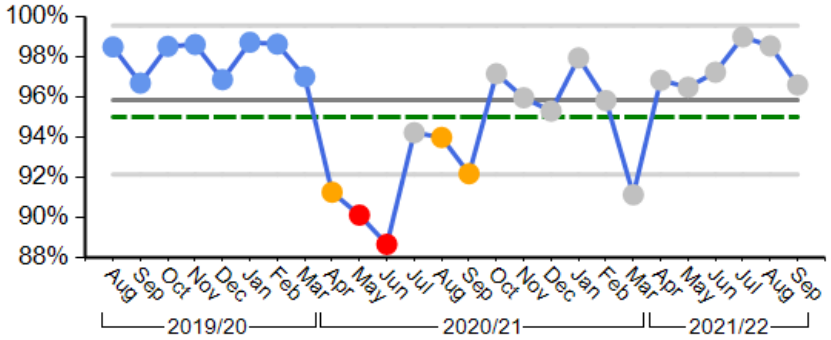
A meeting has been held in October to improve processes around prioritisation of FNOF patients. This is discussed regularly at the T&O Theatre Improvement Group where the Trust is working to further enhance the Golden Patient process. One of the anaesthetists has been assigned to produce a minimum dataset for #NOF patients to minimise anaesthetic delays on the day of surgery.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Sep 21		0	0	Aug 21	0	0	
VTE Prophylaxis Assessments	95%	96.6%	128	Sep 21		95%	98.5%	Aug 21	95%	97.4%	
Fractured Neck of Femur - Operated on within 36Hours	85%	72.2%	5	Sep 21		85%	56.3%	Aug 21	85%	71.4%	
WHO Checklist	100%	100%	0	Sep 21	H	100%	100%	Aug 21	100%	100%	
Safe Staffing	90%	87.1%	N/A	Sep 21		90%	87.2%	Aug 21	90%	88.8%	
Care Hours Per Patient Day (CHPPD)	7	8.5	N/A	Sep 21		7	9	Aug 21	7	9	P
StEIS	0	1	1	Sep 21		0	3	Aug 21	0	13	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.2	2	Sep 21	L	0.5	0.4	Aug 21	0.45	20	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.2	3	Sep 21		0.1	0.4	Aug 21	0.1	11	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.6%	6	Sep 21		2.1%	1.1%	Aug 21	2.1%	0.8%	
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.2	2	Sep 21		0.1	0.1	Aug 21	0.1	0.2	

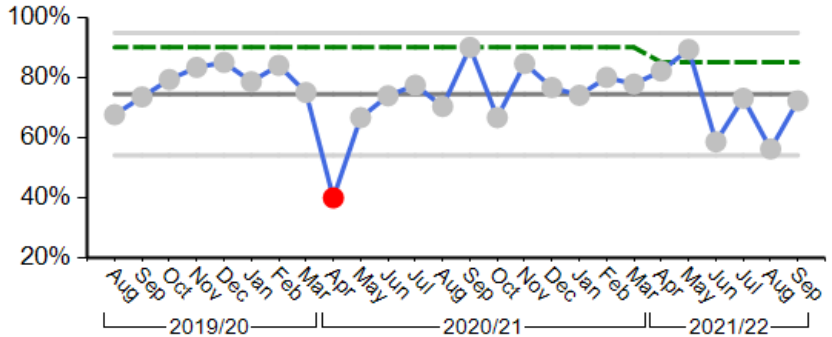
Never Events



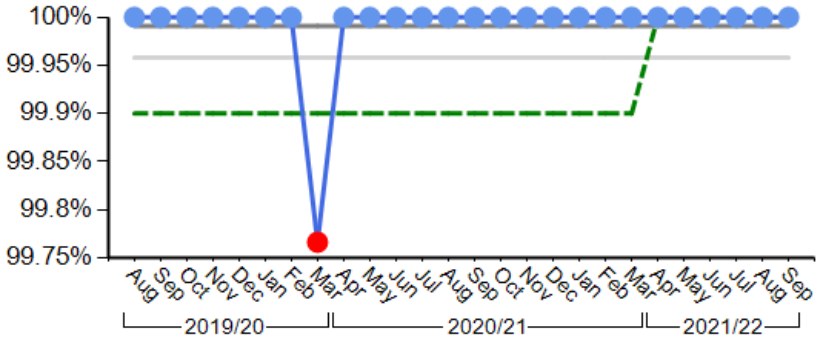
VTE Prophylaxis Assessments



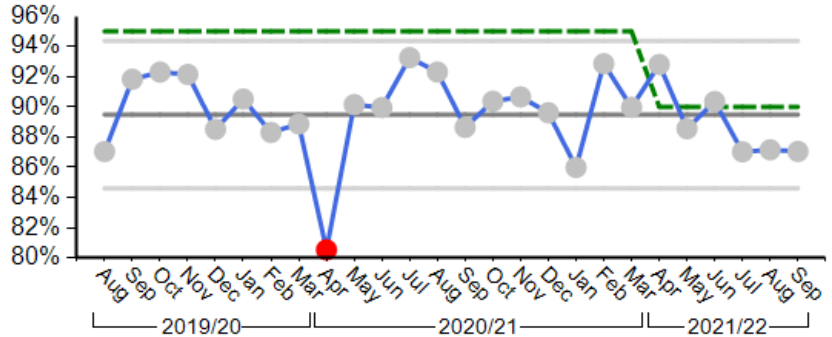
Fractured Neck of Femur - Operated on within 36Hours



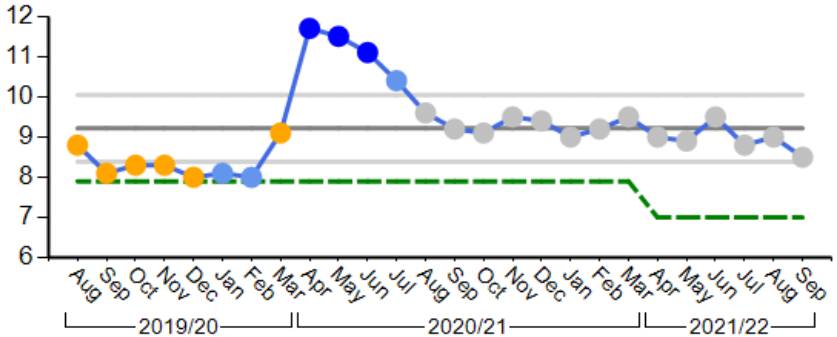
WHO Checklist



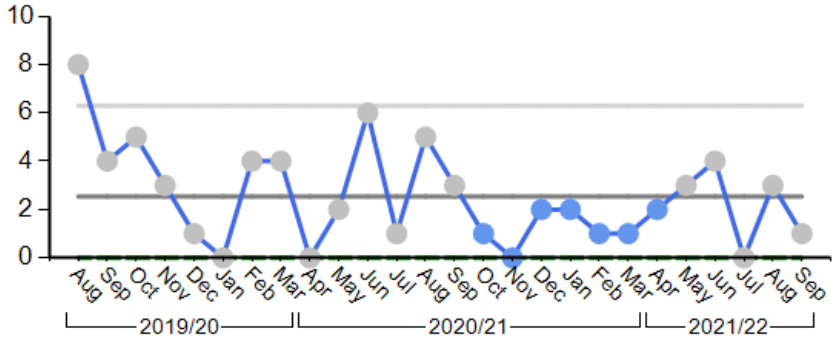
Safe Staffing



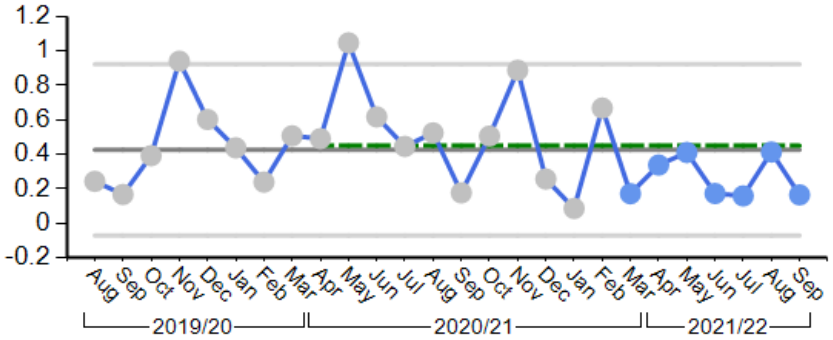
Care Hours Per Patient Day (CHPPD)



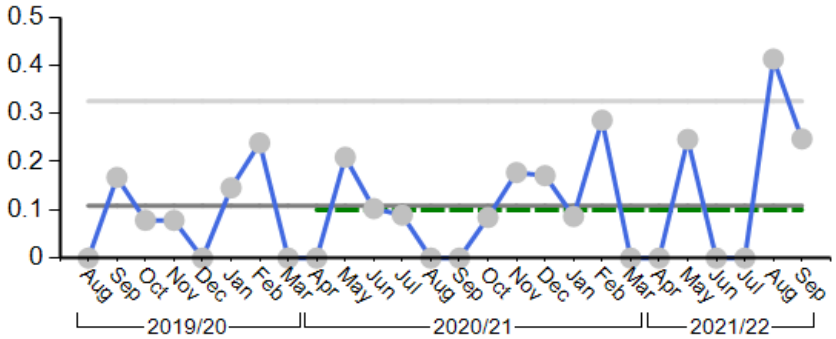
StEIS



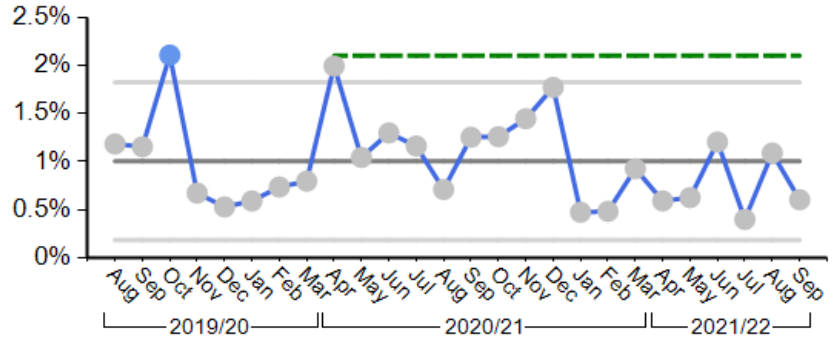
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



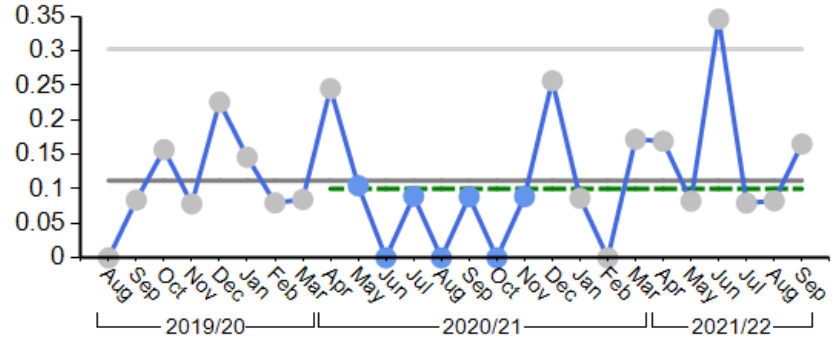
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



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



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



Quality

Infection Prevention and Control

Analyst Narrative:

No indicators within this section are assured. MRSA is showing special cause concern with the last case reported in August. No cases were reported in September. Performance on all other indicators within this section is statistically as expected.

Operational Narrative:

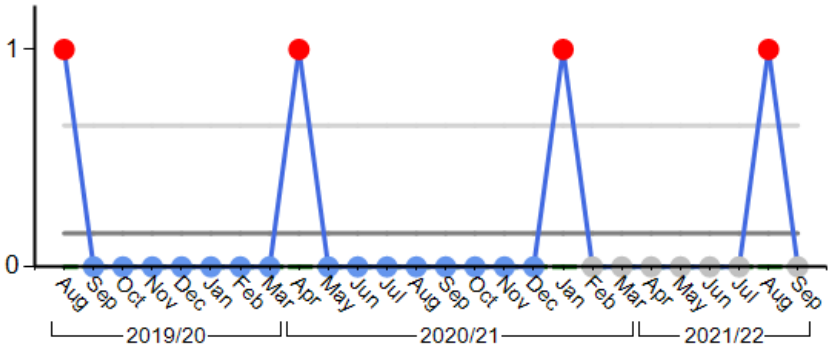
C.diff – 4 Hospital Onset Hospital Acquired cases were reported in September, 2 from Surgical wards and 2 from Medical Wards. 3 of these have been investigated and identified no lapses in care, the remaining one is undergoing an RCA and has identified prolonged use of antibiotics. 2 Community Onset Hospital Acquired cases were reported, both from Medical wards. No lapses in care were identified from these cases.

E. coli – 3 Hospital Onset Hospital Acquired cases were reported, 1 from a Medical ward and 2 from Surgical wards. All cases have been reviewed and all patients were treated appropriately. 2 Community Onset Hospital Acquired cases were reported, 1 from Medicine and 1 from Surgery, investigations have identified no lapses in care.

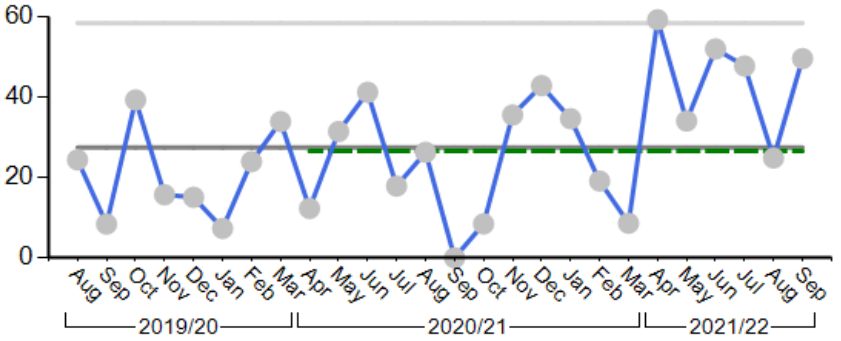
MSSA – 1 Hospital Onset Hospital Acquired case was reported, the patient was having daily reviews and treated appropriately.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Sep 21		0	1	Aug 21	0	1	
Clostridium Difficile - per 100,000 bed days	26.5	49.5	6	Sep 21		26.5	24.8	Aug 21	26.5	44.5	
E. Coli - per 100,000 bed days	20.6	41.3	5	Sep 21		20.6	24.8	Aug 21	20.6	34.5	
MSSA - per 100,000 bed days	8.8	8.3	1	Sep 21		8.8	16.5	Aug 21	8.8	15.2	

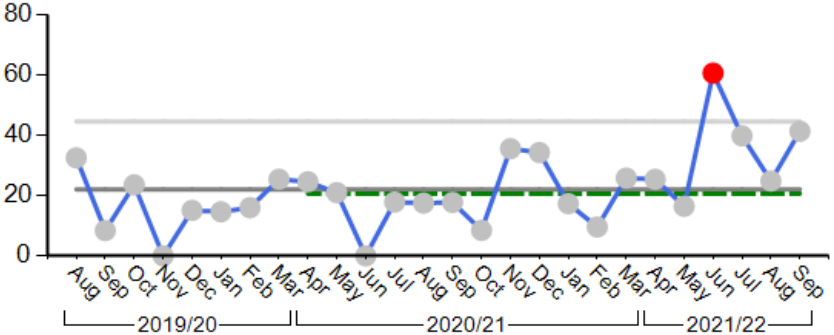
MRSA



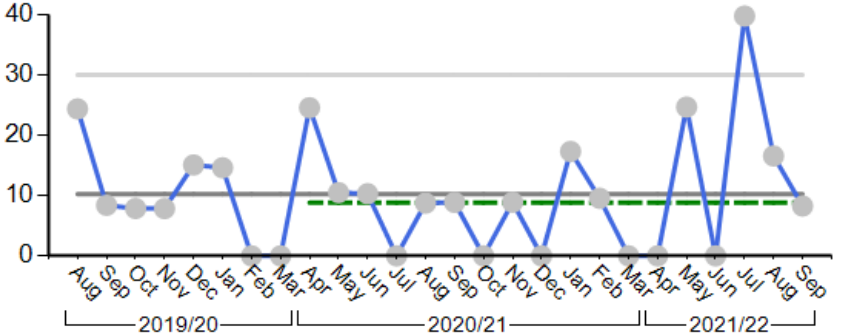
Clostridium Difficile - per 100,000 bed days



E. Coli - per 100,000 bed days



MSSA - per 100,000 bed days



Quality

Maternity

Analyst Narrative:

No indicators within this section are assured but equally none are failing their assurance measure, with variable performance. Following breaches reported in June, July and August resulting in special cause concern, there have been no breaches in the Number of Occasions 1:1 Care Not Provided in September. The Percentage of Women Booked by 12 weeks 6 days is showing special cause concern and has failed to achieve plan in month. Although not statistically significant, both induction of labour and caesarean rates have increased in month. Breastfeeding initiation continues to perform ahead of target and is showing special cause improvement.

Operational Narrative:

One stillbirth was reported in September. This has been reviewed through the Women & Children's Patient Safety meeting.

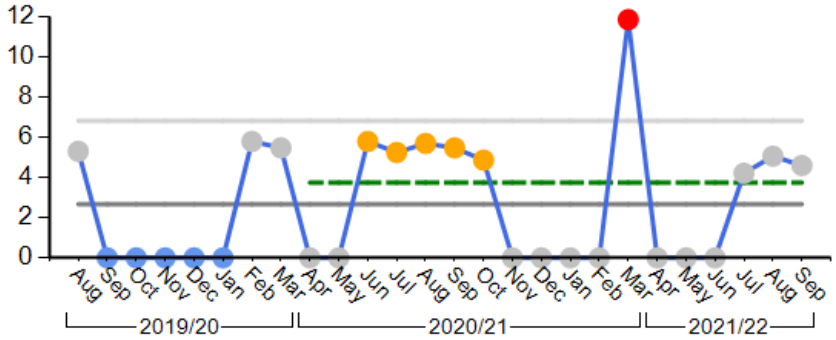
Caesarean Rates and Induction of Labour - This month both Inductions and Caesarean section rates are slightly above plan. An audit has been completed for induction with recommendations based on findings with a plan to report to Quality & Safety Committee and Board quarterly.

28 breaches of the bookings by 12 weeks 6 days were reported in September. Analysis of these breaches identified maternal reasons as accounting for 22 of the 28 breaches, for example women booking late as they were unaware of the pregnancy. There was an 18% increase in bookings from August to September and only 2 breaches were reported due to service capacity.

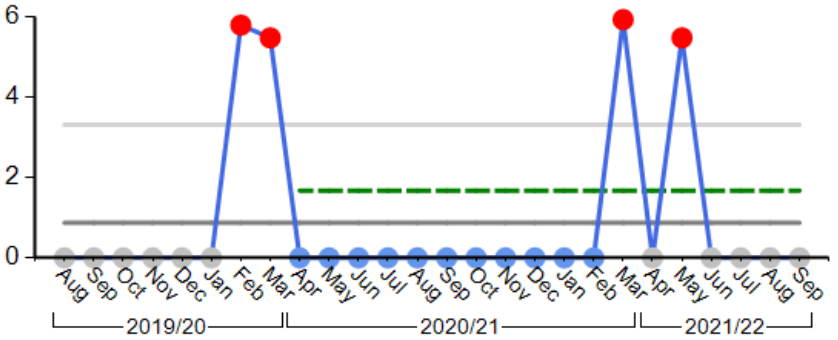
3rd and 4th Degree Tears - All cases are reviewed at the Patient Safety Meeting and care was appropriate. No themes with midwife conducting births.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Stillbirth Rate (per 1,000 births)	3.74	4.6	1	Sep 21		3.7	5.1	Aug 21	3.74	2.5	
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Sep 21		1.7	0	Aug 21	1.67	0.8	
Number of Maternal Deaths	0	0	0	Sep 21		0	0	Aug 21	0	0	
Caesarean Rates	28.5%	36.7%	80	Sep 21		28.5%	28.8%	Aug 21	28.5%	35.2%	
Induction Rate	38%	39.4%	86	Sep 21		38%	38.9%	Aug 21	38%	43.3%	
Breastfeeding Initiation	62%	64.8%	76	Sep 21	H	62%	67.5%	Aug 21	62%	64.5%	
Percentage of Women Booked by 12 weeks 6 days	90%	87%	28	Sep 21	L	90%	91.2%	Aug 21	90%	90%	
Number of Occasions 1:1 Care Not Provided	0	0	0	Sep 21	H	0	1	Aug 21	0	4	
Maternity Complaints as % of Deliveries	0.7%	0.5%	1	Sep 21		0.7%	1%	Aug 21	0.7%	0.6%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	2.6%	3	Sep 21		1.5%	3.7%	Aug 21	1.5%	2.8%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	0%	0	Sep 21		11%	4.2%	Aug 21	11%	3.6%	

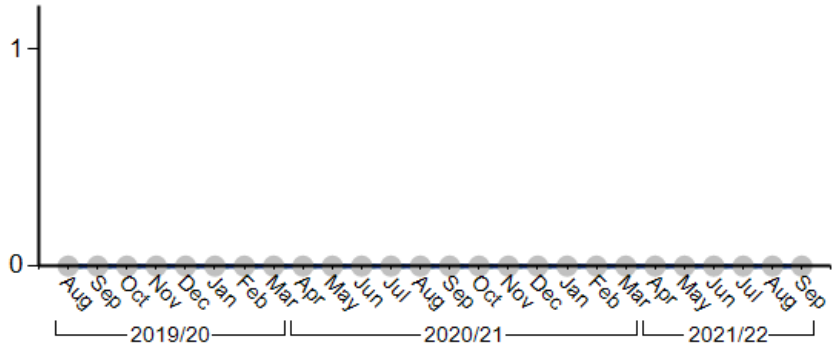
Stillbirth Rate (per 1,000 births)



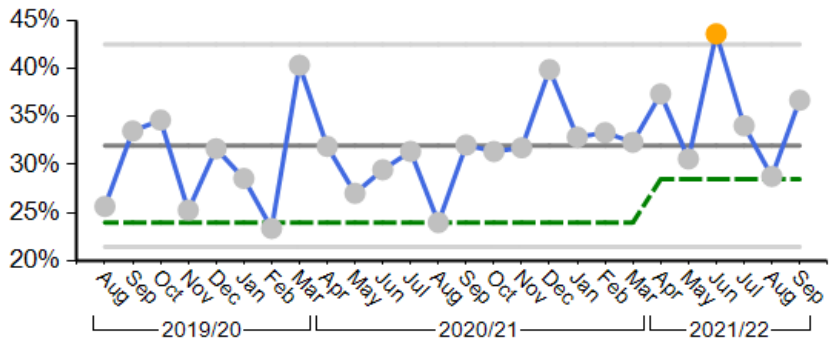
Neonatal Mortality Rate (per 1,000 births)



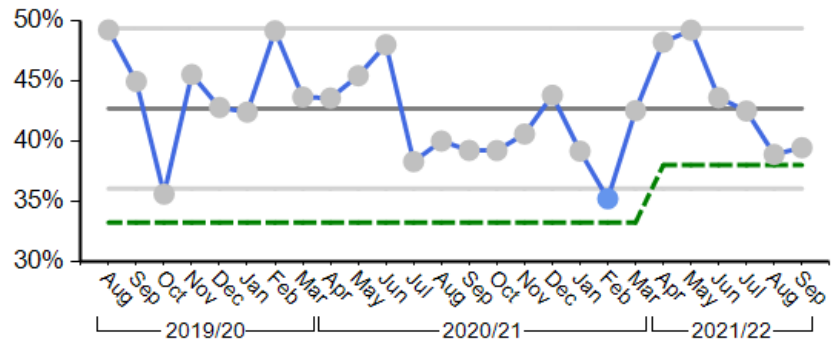
Number of Maternal Deaths



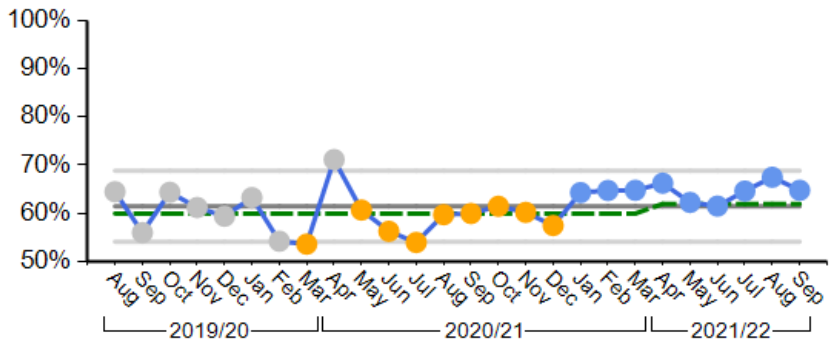
Caesarean Rates



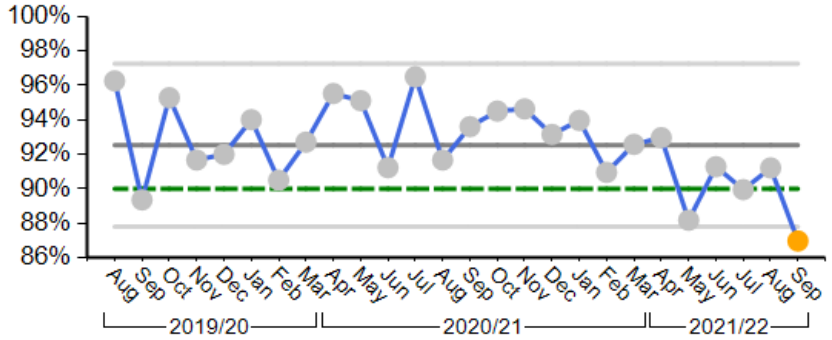
Induction Rate



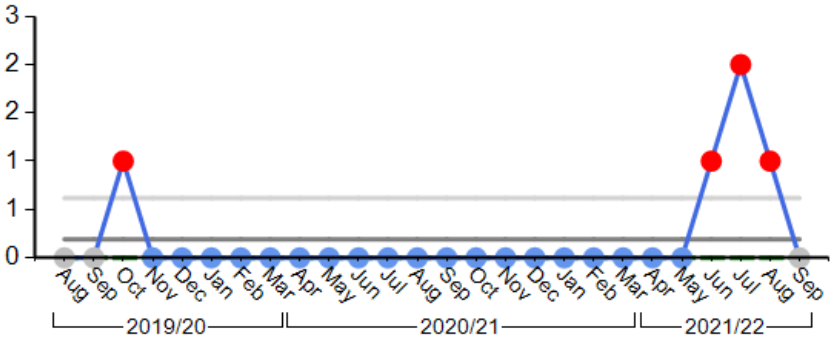
Breastfeeding Initiation



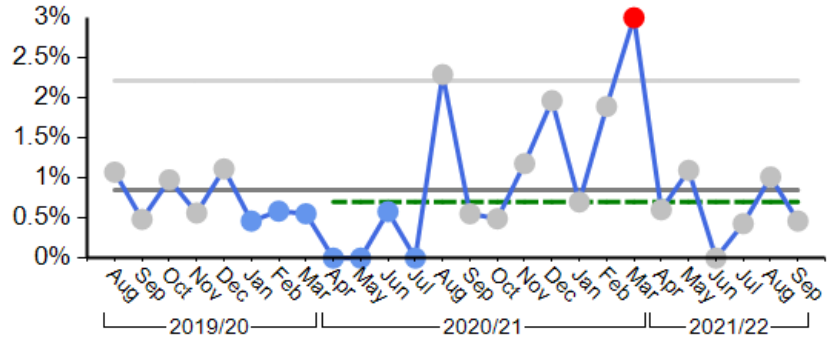
Percentage of Women Booked by 12 weeks 6 days



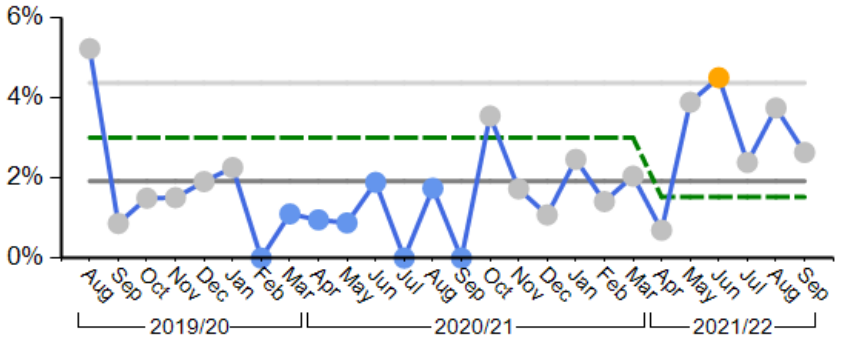
Number of Occasions 1:1 Care Not Provided



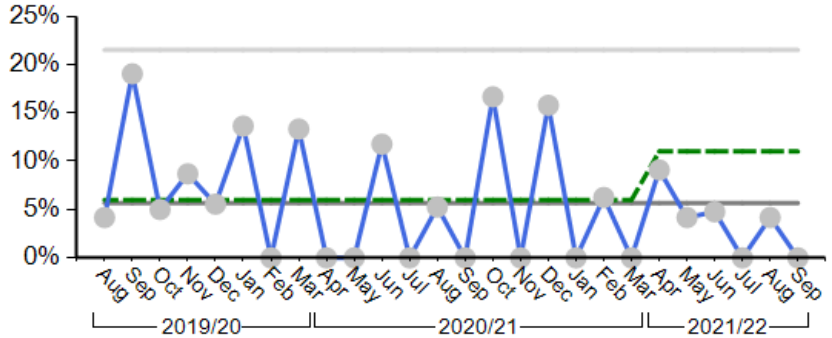
Maternity Complaints as % of Deliveries



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



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



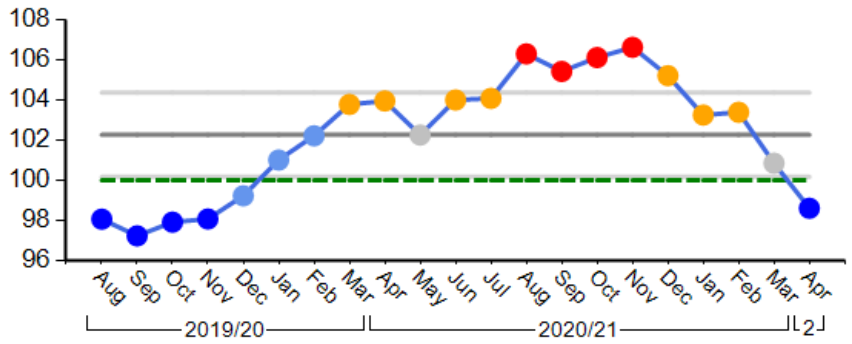
Quality

Mortality

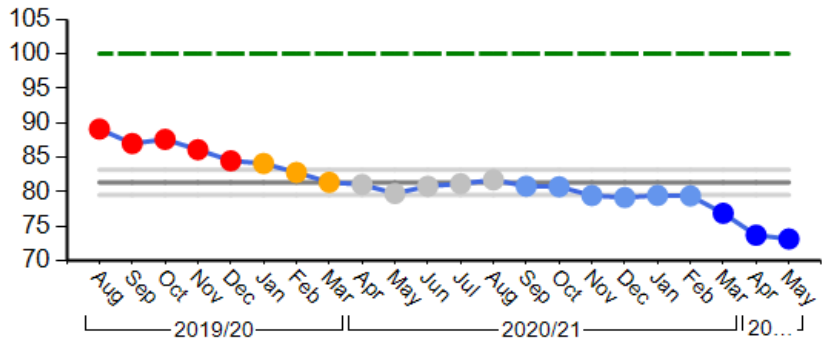
The latest SHMI, for the 12-month period ending April 2021 is 98.6. This is statistically as expected. The HES forecast is predicting Trust SHMI will remain below 100 in the next release and will still be in the 'as expected' category. Nationally sourced data now includes April 2021 and the percentage of spells excluded from mortality reporting has dropped to 5.3%. This is now 1,610 spells which have been removed from the mortality reporting process. The HSMR continues to be assured and there are no local SMR's above 100 for this reporting period (August 2021). The Mortality screening remains low but some retrospective screens undertaken within Planned Care for July and August have increased compliance marginally. Provisional screening results for September show a significant increase in compliance due to role of the Medical Examiner's Officer.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	98.6	N/A	Apr 21		100	100.9	Mar 21	100	98.6	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	73.2	N/A	May 21		100	73.7	Apr 21	100	73.2	
Percentage of Deaths Screened	100%	10.4%	69	Aug 21		100%	13.5%	Jul 21	100%	13.3%	
Perinatal Mortality Rate	5.4	4.5	4.52	Sep 21		5.4	5.1	Aug 21	5.4	3.2	

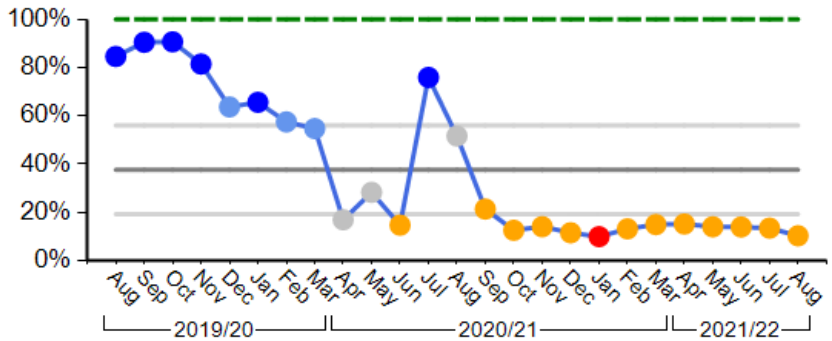
SHMI (Summary Hospital-level Mortality Indicator)



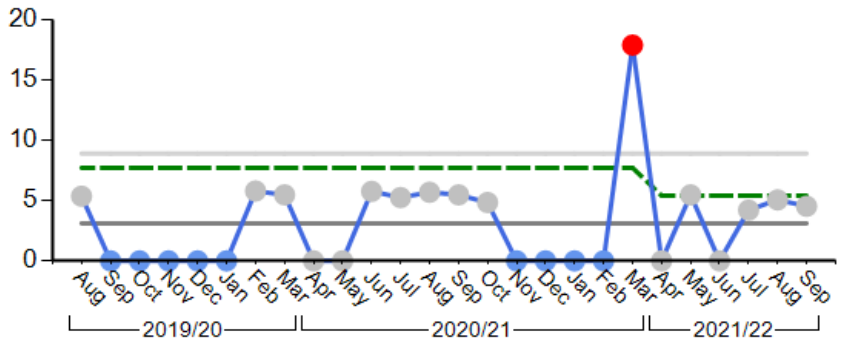
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Perinatal Mortality Rate



Quality

Patient Experience

Analyst Narrative:

The Friends and Family Response Rate continues to be assured and show special cause improvement with a further increase in September. Both Duty of Candour indicators continue to show special cause improvement, maintaining 100% compliance in September. The Friends and Family Test - % that would recommend continues to show special cause concern with performance in September remaining static, but almost 6% below the target. Although not statistically significant, the number of Delivering Same Sex Accommodation breaches has increased in September.

Operational Narrative:

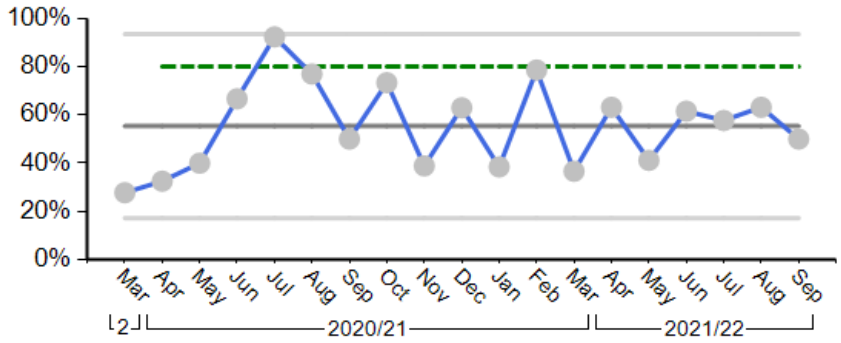
10 Delivering Same Sex Accommodation breaches were reported in September. Two relate to delayed discharges from Critical Care and eight relate to the Clinical Decision Unit, caused by the bed occupancy and flow issues experienced in September.

The Friends and Family Test - % That Would Recommend has declined marginally in September with declines noted in Specialist Services and Medicine & Emergency Care, whilst Planned Care have had an increase of over 3%. Women & Children's continue to drive an increase in their response rates, for example addressing the issue with the capture of the FFT in Neonatal. Within the feedback from the FFT in SDGH A&E the main area of concern is in the ED environment, however when compared to peer this was favourable. The detail has been presented at the Q&S Committee and the action plan will be monitored via the CBU Governance Meeting and the Patient Experience Committee.

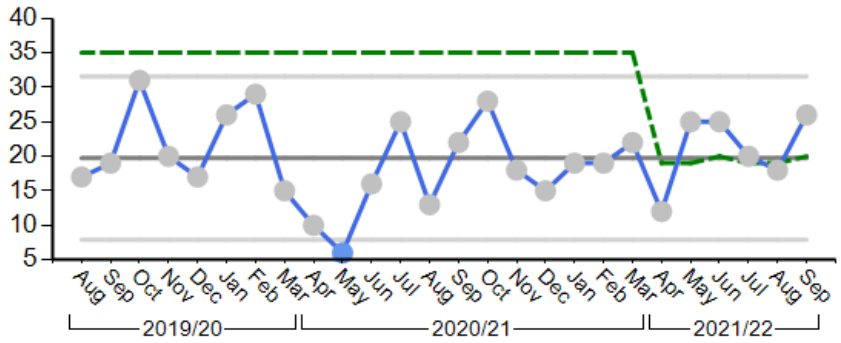
Closure of complaints within the timescales continues to be a challenge, impacted by capacity. The work of the weekly Complaints Review Group continues to address any delays in answering complaints.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	50%	N/A	Sep 21		80%	63.2%	Aug 21	80%	56.6%	
Written Complaints	20	26	26	Sep 21		19	18	Aug 21	233	126	
Friends and Family Test - Patients - % Response Rate	15%	24.1%	6102	Sep 21	H	15%	23%	Aug 21	15%		P
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	88.3%	227	Sep 21	L	94%	88.4%	Aug 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	L	83%	NTR	Jun 21	83%	51.5%	F
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	10	10	Sep 21		0	2	Aug 21	0	28	
Duty of Candour - Evidence of Discussion	100%	100%	0	Sep 21	H	100%	100%	Aug 21	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	Sep 21	H	100%	100%	Aug 21	100%	100%	

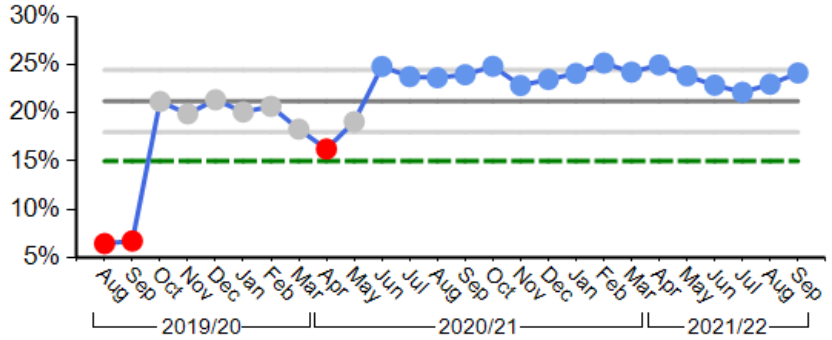
Complaints - % closed within 40 working days



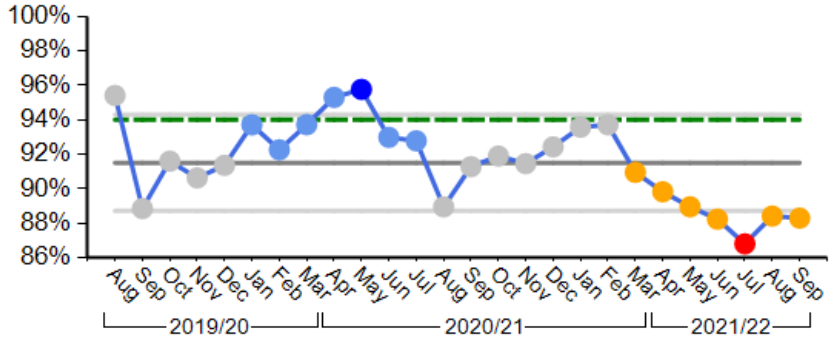
Written Complaints



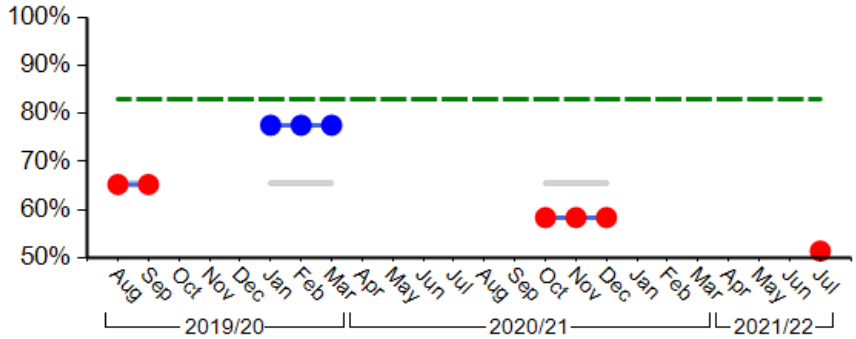
Friends and Family Test - Patients - % Response Rate



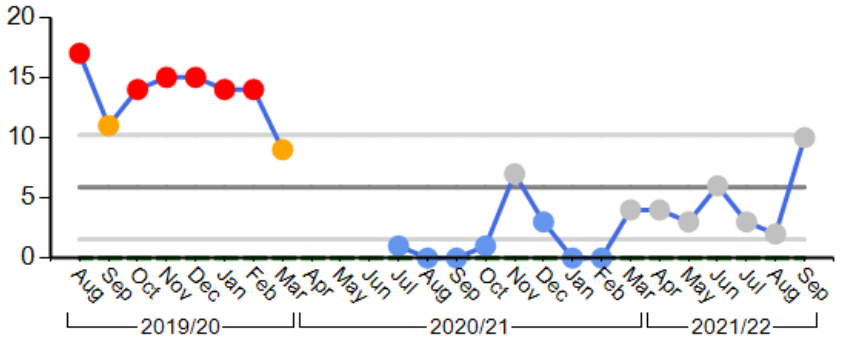
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



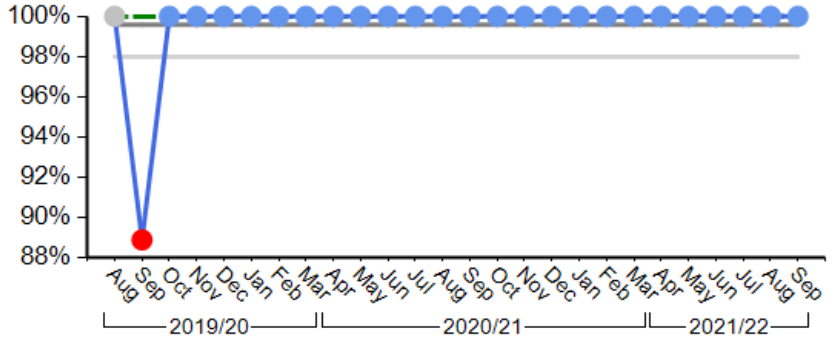
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



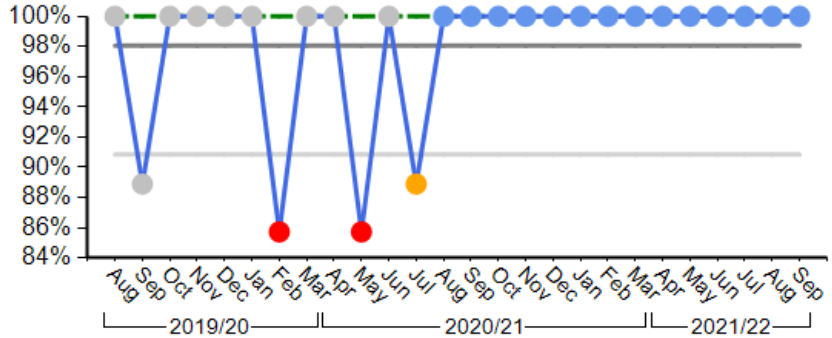
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Workforce

Organisational Development

Analyst Narrative:

Mandatory Training continues to be assured and despite a slight decline in September remains 3% ahead of the target. Personal Development Reviews continue to show special cause improvement with a 0.9% increase in September.

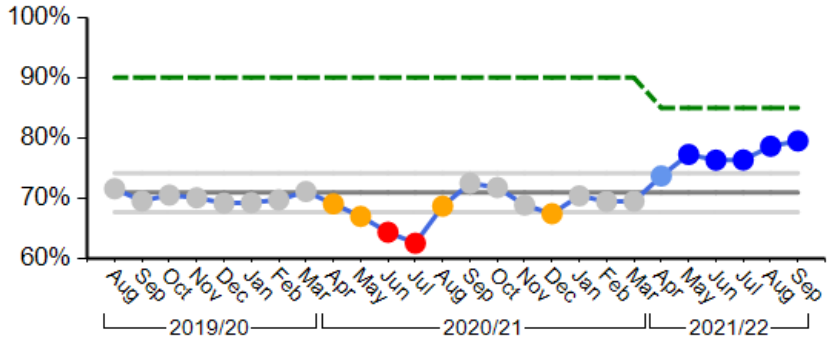
Operational Narrative:

Continued access to online training allows staff to access most of the mandatory training courses 24/7 to keep up to date. This approach has significantly improved the Trust's ability to maintain above target compliance over the last 6-12 months throughout the Covid19 pandemic. The Trust remains in a good position to manage and monitor mandatory training through its robust processes and systems to provide continued assurance. Acknowledgement and thanks should be given to staff and managers across the organisation who monitor this monthly.

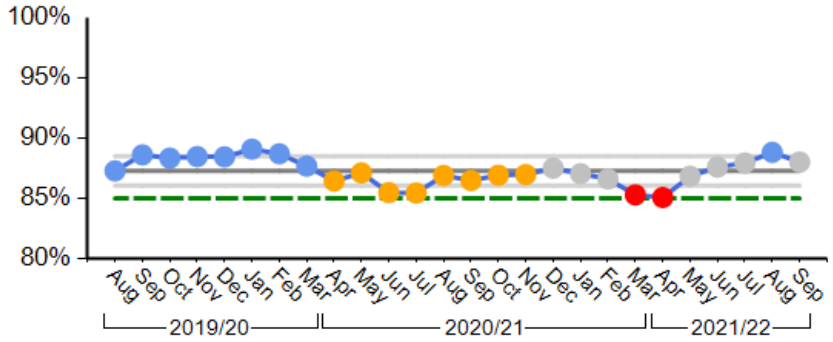
Please also refer to supplementary action plan for PDR's.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	79.5%	N/A	Sep 21		85%	78.6%	Aug 21	85%	77%	
Mandatory Training	85%	88%	N/A	Sep 21		85%	88.8%	Aug 21	85%	87.4%	
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%	

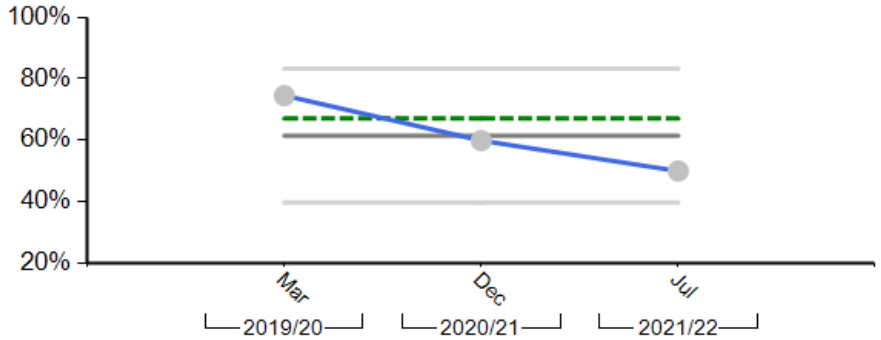
Personal Development Review



Mandatory Training



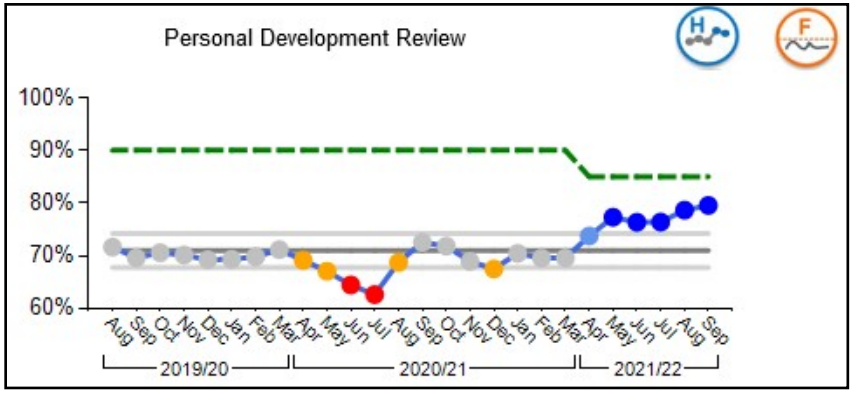
Staff Survey - I would recommend my organisation as a place to work



Non Medical Appraisal/Personal Development Reviews

Southport and Ormskirk Hospital NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Personal Development Review	85%	79.5%	N/A	Sep 21	H	85%	78.6%	Aug 21	85%	77%	F



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

Situation: The increased focus on compliance remains in place with further gradual improvements throughout the trust. The September figure is 79.52% (up by 0.88% in month when compared to August). There have been some good results this month though with Corporate figures increasing to 83.84% which is an overall improvement of 20.17% in month. This is as a result of direct intervention at Exec Director level but this level of intervention should not be required within the organisation.

Estates and Facilities have further improved compliance to 81.37%

The three CBUs are hovering between 78.21% and 79.34% in terms of compliance

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%.

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

Mitigations:

PDR improvement from May to September have been made, with incremental monthly increases throughout. September 2021 has the best compliance rate this performance year.

Corporate and estates and Facilities teams are now performing well against target with just small improvements now needed to hit the Trust 85% target. Continued focus will be required during October.

Phase 2 of the PDR action plan has been deferred to January 2022 to allow clinical staff to focus on patent care and safety as we move towards Winter.

Workforce

Sickness, Vacancy and Turnover

Analyst Narrative:

Several indicators are failing their assurance measure in relation to Sickness, Vacancies and Turnover. The sickness rate remains high at 6.7%, consistent with the previous month and the rolling 12-month rate has increased by 0.1% to 6.5%. This is due to non-Covid sickness rates. Medical vacancy rates continue to show special cause improvement although they have increased in September and have breached the target. Nursing vacancy rates remain static. The rolling staff turnover is showing special cause concern and has breached the third upper control limit in September.

Operational Narrative:

Whilst we are still slightly above target for time to hire this has been investigated and was due to the final students taking up post in September, and to maintain this level whilst we have a significant amount of recruitment activity and a vacancy in the team is a notable performance. The medical time to hire was excellent in September, mainly driven by in country appointments.

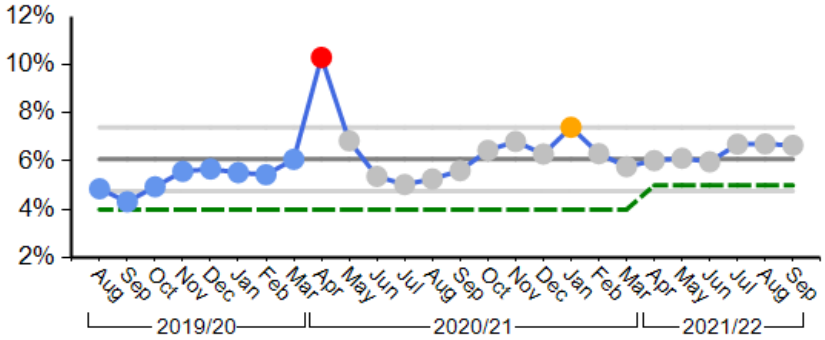
The rise in medical vacancy can in part be attributed to some late actioning of forms submitted in August and the TUPE of the Haematology doctors. The TUPE is not being actioned until October so the budget still remains, but the terminations were actioned in September, which was the original plan. A delay in completing the TUPE actually means the doctors are being re-hired for the month of October but due to the reporting timeframe this is not reflected in the figures.

The vacancy rate rise was anticipated, given the amount of recruitment activity however we do currently have 205 posts under offer, excluding the overseas nurses. It is therefore anticipated that this will improve very quickly. We currently have 30 medical posts under offer, 55 external nursing posts (Band 5 upwards) along with 15 AHPs, therefore we are managing to attract significant interest in our advertised vacancies.

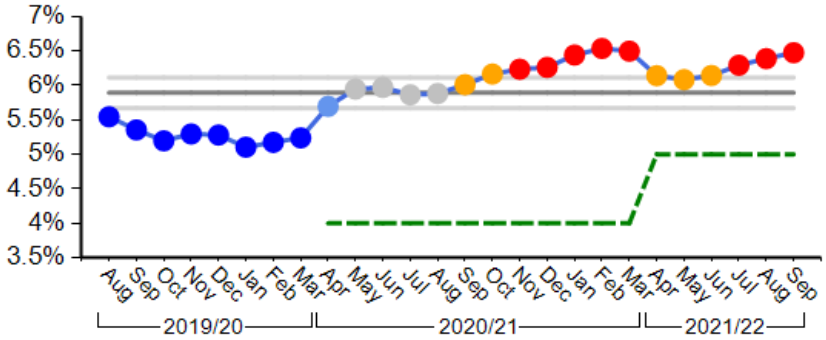
Please also refer to supplementary action plan for Sickness Absence.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	5%	6.7%	N/A	Sep 21		5%	6.7%	Aug 21	5%	6.4%	
Sickness Rate (Rolling 12 Month)	5%	6.5%	N/A	Sep 21	H	5%	6.4%	Aug 21	5%	6.3%	F
Sickness Rate - Medical Staff	5%	1.8%	N/A	Sep 21		5%	1.6%	Aug 21	5%	1.7%	P
Sickness Rate - Nursing Staff	5%	8.2%	N/A	Sep 21		5%	9.3%	Aug 21	5%	8.4%	
Sickness Rate (not related to Covid 19) - Trust		6%	N/A	Sep 21	H		6%	Aug 21		5.8%	
Trust Vacancy Rate – All Staff	6.8%	10%	N/A	Sep 21		6.8%	8.8%	Aug 21	6.8%	9.3%	F
Vacancy Rate - Medical	7.4%	8.6%	N/A	Sep 21	L	7.4%	6.9%	Aug 21	7.4%		F
Vacancy Rate - Nursing	9%	10%	N/A	Sep 21	L	9%	10%	Aug 21	9%		F
Staff Turnover	0.75%	1.2%	N/A	Sep 21		0.8%	1.7%	Aug 21	9%	6.8%	
Staff Turnover (Rolling)	10%	14.4%	N/A	Sep 21	H	10%	14%	Aug 21			F
Staff Turnover - Nursing	0.8%	1.4%	N/A	Sep 21		0.8%	1.4%	Aug 21	9.6%	1.3%	
Time to Recruit	55	58	N/A	Sep 21		55	59	Aug 21	55	56	

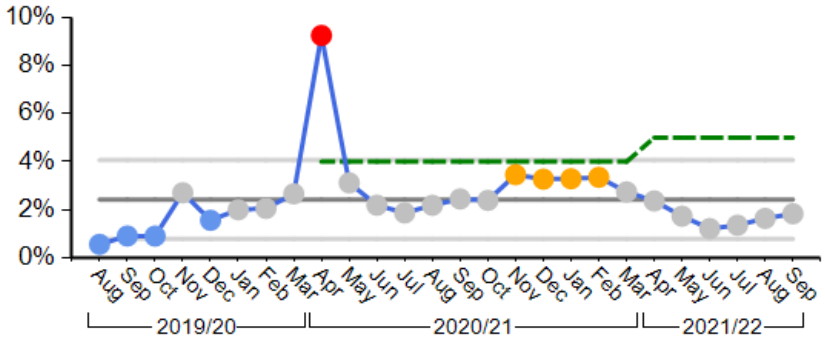
Sickness Rate



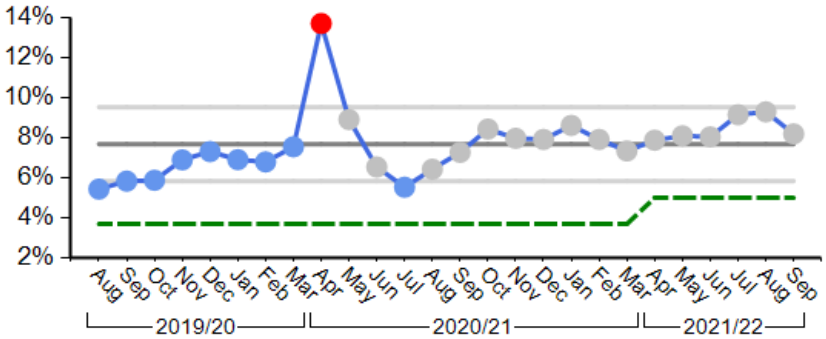
Sickness Rate (Rolling 12 Month)



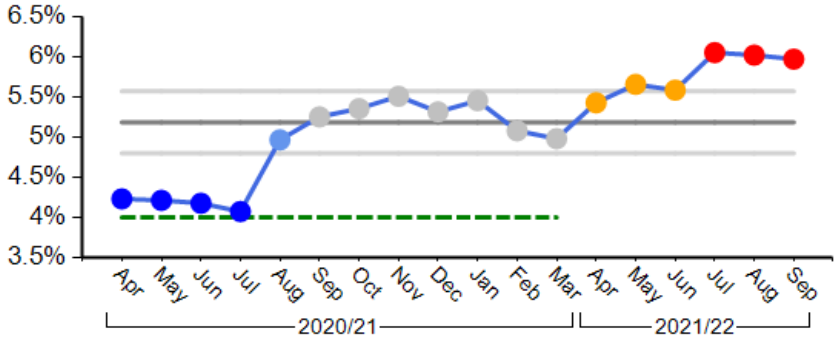
Sickness Rate - Medical Staff



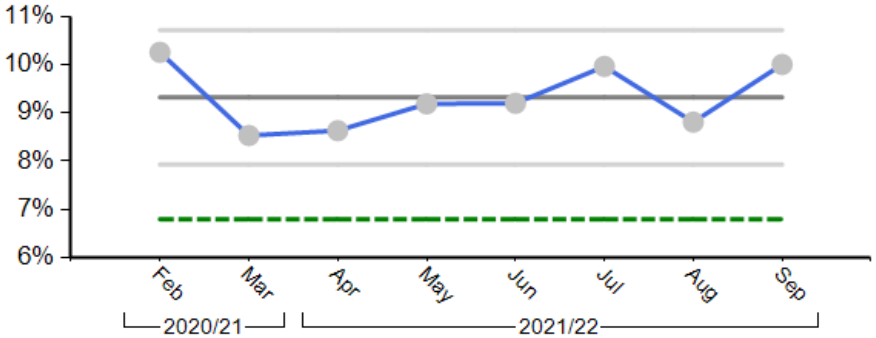
Sickness Rate - Nursing Staff



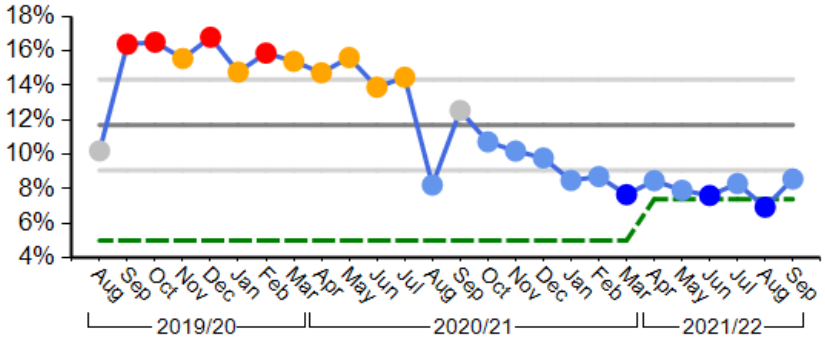
Sickness Rate (not related to Covid 19) - Trust



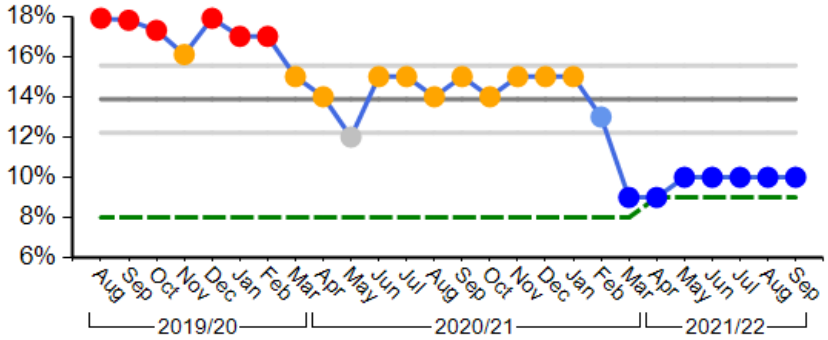
Trust Vacancy Rate – All Staff



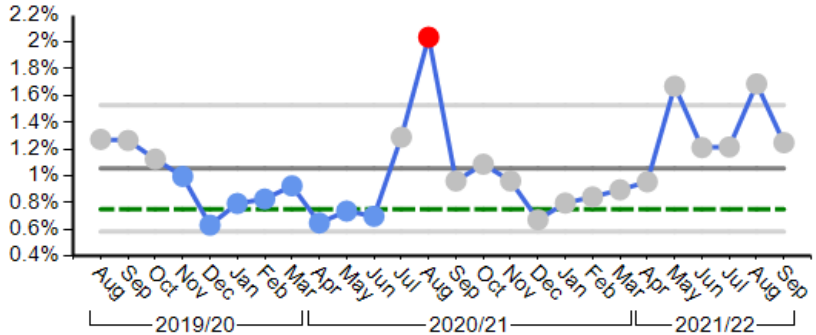
Vacancy Rate - Medical



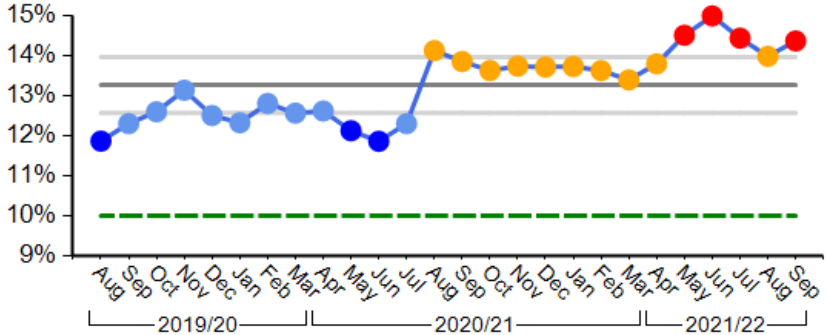
Vacancy Rate - Nursing



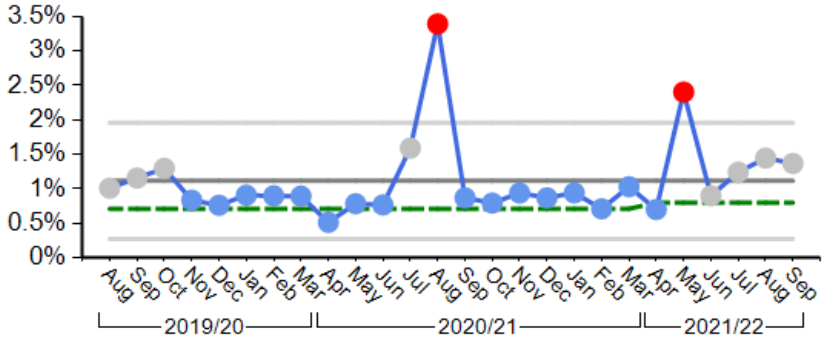
Staff Turnover



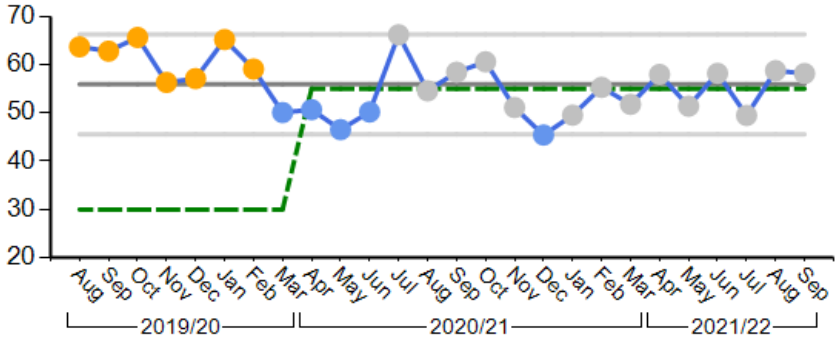
Staff Turnover (Rolling)



Staff Turnover - Nursing



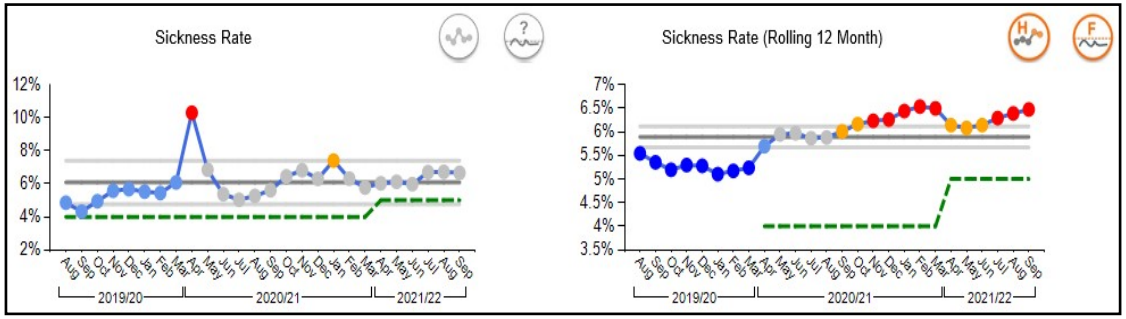
Time to Recruit



Sickness Absence

NHS
Southport and Ormskirk Hospital
NHS Trust

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness Rate	5%	6.7%	N/A	Sep 21		5%	6.7%	Aug 21	5%	6.4%	
Sickness Rate (Rolling 12 Month)	5%	6.5%	N/A	Sep 21	H	5%	6.4%	Aug 21	5%	6.3%	F



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

Situation: As we continue into recovery phase sickness levels remain pretty static over the last three months. Interestingly in September there was an increase in the number of separate absences from the previous month at 684 compared to 616 in August. So, although there was an increase in short term absence the cases closed have balanced out the overall sickness rate for the Trust. Top three absence reasons remain stress / anxiety / depression followed by MSK and back problems. Rolling 12m absence rate has risen slightly by 0.1%. The focus on absence is three fold, long term sickness absence, targeting two week absences before they tip into long term and helping people to reman in work through wellbeing conversations, risk assessments and reasonable adjustments.

Issues:

Long term to short term ratio has reduced to approximately 1.6:1 and for the first time in 12 months there has been a drop in long term absence to 61.66% of monthly total (previously over 70%)

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 and is being rolled out across other CBUs too

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 within this section are failing their assurance measure: A&E – 4-hour compliance, Ambulance Handover 30-60 mins, Diagnostic Waits and Referral to Treatment: ongoing. The A&E 4-hour compliance, 12 Hour trolley waits and the number and percentage of patients spending longer than 12 hours in A&E are all showing special cause concern this month. Whilst the overall 4-hour compliance remains fairly static, the number of 12-hour trolley waits and the number and percentage of patients spending longer than 12 hours in A&E have risen significantly in September. Diagnostic waits continues to show special cause concern with a 0.9% decrease in performance in September. All Referral to Treatment indicators are showing special cause concern as the overall waiting list continues to increase.

Operational Narrative:

90% stay on the Stroke Unit: - performance in this area remains stagnant at 65.5% against a target of 80%; the Directorate has undertaken a detailed analysis of the breaches from April to August 2021 to identify any performance trends. This analysis has demonstrated that bed capacity is becoming less of a risk since April 2021 likely related to the relocation of the Stroke Unit to Ward 15B and increased number of side rooms. For patients who are admitted straight to the stroke ward, compliance continues to be impacted by the length of time the patient is in ED, coupled with an average LOS of less than 2 days. Several patients in July and August were impacted by delayed diagnosis and late or no referral to the Stroke Team, signalling the need to improve education of the pathway.

TIA Performance improved slightly but performance remains erratic; the Directorate has provided an improvement plan.

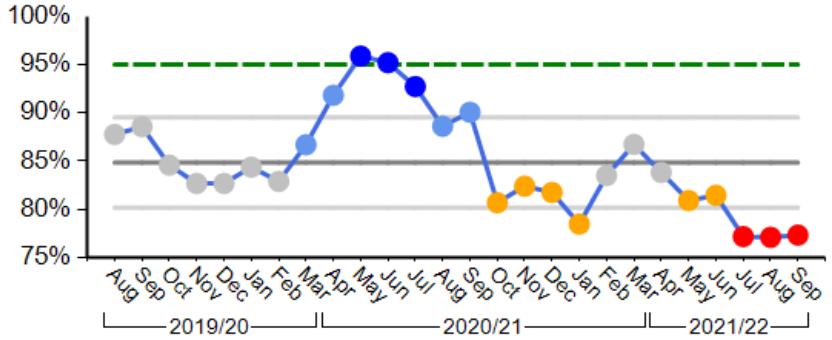
Significant pressures remained across all ED's in September 2021 with Cheshire & Mersey reporting 73.3%, the North West 71.96% and nationally 75.2%. ED Performance overall against the 4-hour standard at SDGH remains consistent; September saw a significant surge in activity at SDGH with high levels of occupancy 24/7; this coupled with significant nurse staffing challenges contributed to an increase in 12-hour breaches; the CBU can provide assurance however that all reviews of 12-hour breaches demonstrate good standards of care and no instances of harm despite the significant wait. Assurance reports are summited to NHSE within 48 hours of occurrence. Unfortunately, in September the department held an increased number of ambulances for an excess of 1 hour. Whilst ambulance handover times increased the trust were still in the top quartile across Cheshire and Merseyside. The Trust maintained zero corridor care in September.

Diagnostics – Performance continues to be impacted by high demand and staffing challenges. SBAR's and recovery plans are being developed for each of the modalities. These will be presented to SOLT for assurance.
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, information taken from the latest slides from the Endoscopy network show that our waiting list has increased by 150% since September, new additions has increased by 30% and our activity has increased by 33%. The nursing team staffing has continued to improve and addition sessions can now commence within the unit which will include 2 Saturdays of six sessions on each. The training plan going forward is to send over our nursing staff to LUFT to gain ERCP experience in a much quicker timescale (LUFT perform over 10 ERCP per day we currently average 4 per week). This will strengthen our own service so we can maintain the service in house.

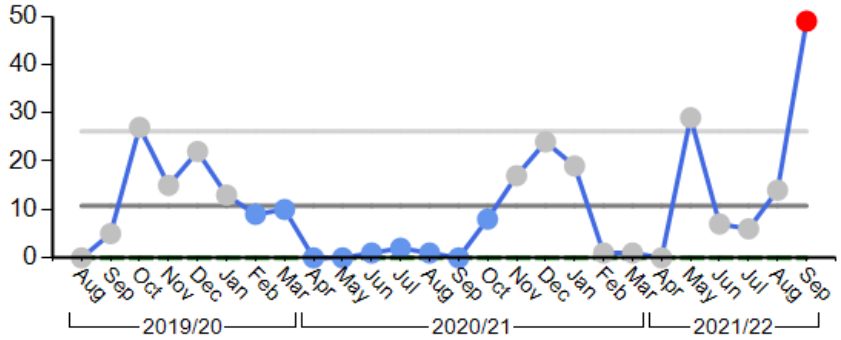
RTT - Improvements seen across all points of delivery from August to September 2021, however still seeing impact of covid/non-covid absence especially through direct contacts testing positive e.g. staff member school children.
Overall elective inpatient activity is significantly above plan at 114% against a national target of 95% of 19/20 levels – showing the complex nature of current activity. Challenged specialty is urology (84%). Improvements in T+O (136%), General Surgery (100%) and Gynaecology (183%).
Elective day case is below plan by 30% in September at 65% against a national target of 95% of 19/20 levels. Challenged specialties below average are endoscopy, ophthalmology, oral surgery, ENT, gynaecology and haematology. Urology continues to perform – 114%. Complexity of cases also impacts ability to do daycase. Outpatient activity is above plan for first attendances but under by 5% on follow up attendances. Challenged specialties remain ophthalmology, general surgery, clinical haematology and general medicine.
GP referrals for 3 month period including July, August & September 2021/22 are 31.72% lower than the corresponding period in 2019/20 however urgent 2 week wait referrals are up by 13.6% in the same 3 month period compared to 2019/20.
Potential impact COVID-19 activity on elective restoration plans due to Wave 3.
52 week waits – 35% of the 52+ week waiters have a TCI in place for treatment. The push on P2's continues. SOHT accounts for 1% of all 52+ week waiters in Cheshire & Mersey and is below planned trajectory levels.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	77.4%	2248	Sep 21		95%	77.1%	Aug 21	95%	79.6%	
Accident & Emergency - 12+ Hour trolley waits	0	49	49	Sep 21		0	14	Aug 21	0	105	
Number of Patients spending 12+ Hours in ED - Trust		712	N/A	Sep 21			456	Aug 21		2531	
% of Patients spending 12+ Hours in ED - Trust		9.3%	N/A	Sep 21			6.3%	Aug 21		5.5%	
Ambulance Handover 30-60 Mins	0	104	104	Sep 21		0	50	Aug 21	0	336	
Ambulance Handover Over 60 Mins	0	28	28	Sep 21		0	8	Aug 21	0	72	
Diagnostic waits	1%	35.7%	2161	Sep 21		1%	34.8%	Aug 21	1%	25%	
Referral to treatment: on-going	92%	82.1%	2318	Sep 21		92%	83%	Aug 21	92%	83%	
Total RTT Waiting List - Trust		12929	12929	Sep 21			12595	Aug 21		12929	
Total 52 week waits – completed		54	N/A	Sep 21			47	Aug 21		500	
52 Week Waits	0	135	135	Sep 21		0	132	Aug 21	0	242	
Stroke - 90% Stay on Stroke Ward	80%	65.5%	10	Aug 21		80%	65.6%	Jul 21	80%	65.2%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	28.9%	27	Aug 21		60%	15.8%	Jul 21	60%	28.4%	

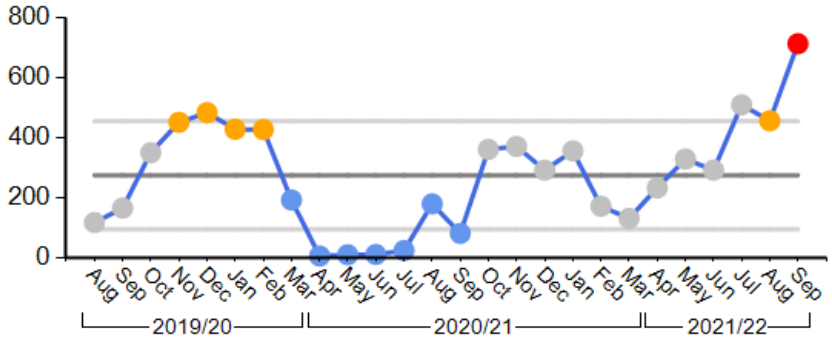
Accident & Emergency - 4 Hour compliance



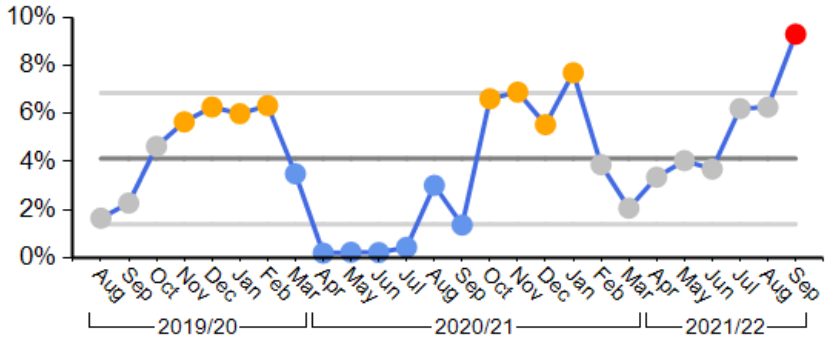
Accident & Emergency - 12+ Hour trolley waits



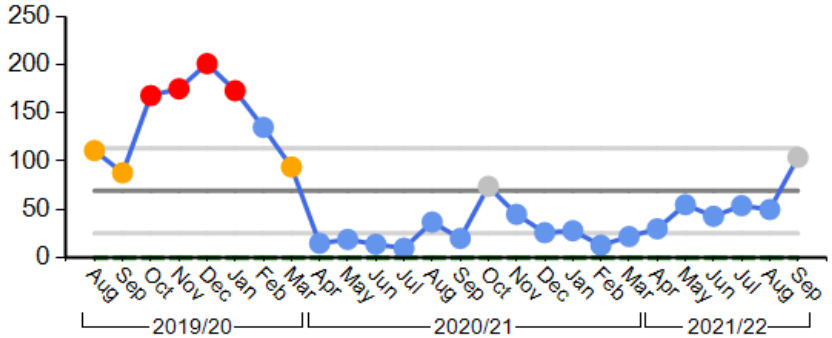
Number of Patients spending 12+ Hours in ED - Trust



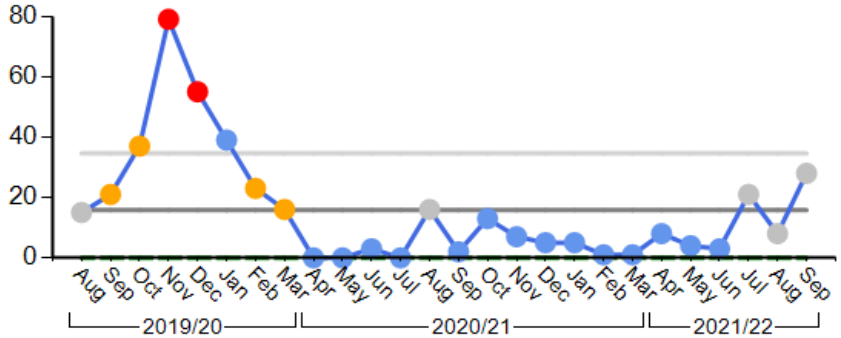
% of Patients spending 12+ Hours in ED - Trust



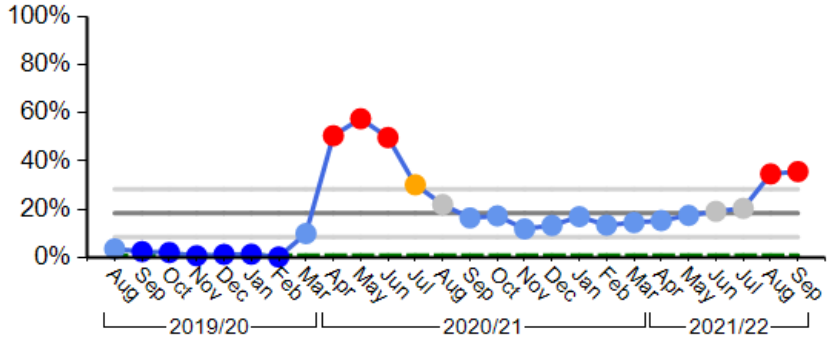
Ambulance Handover 30-60 Mins



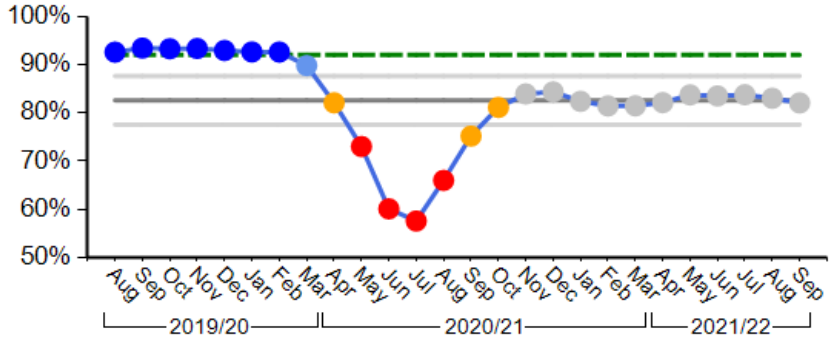
Ambulance Handover Over 60 Mins



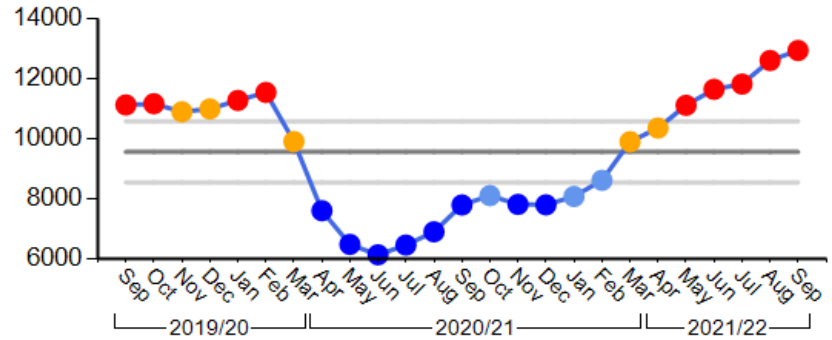
Diagnostic waits



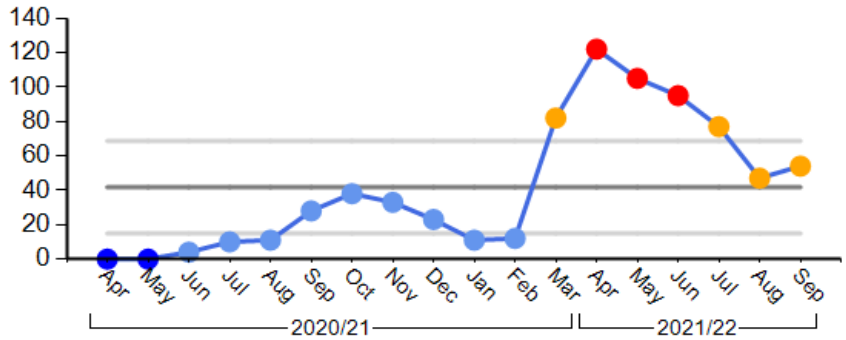
Referral to treatment: on-going



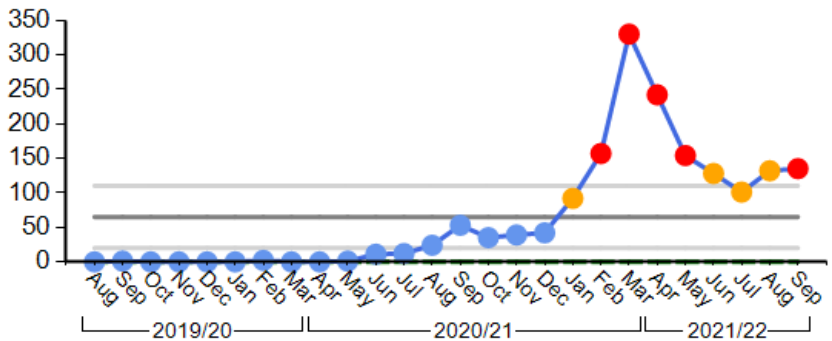
Total RTT Waiting List - Trust



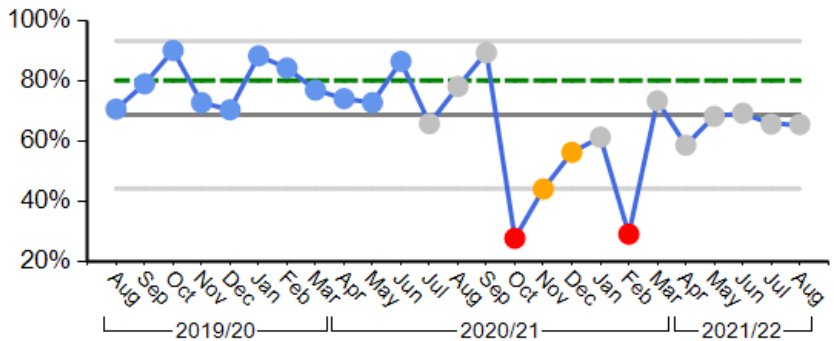
Total 52 week waits – completed



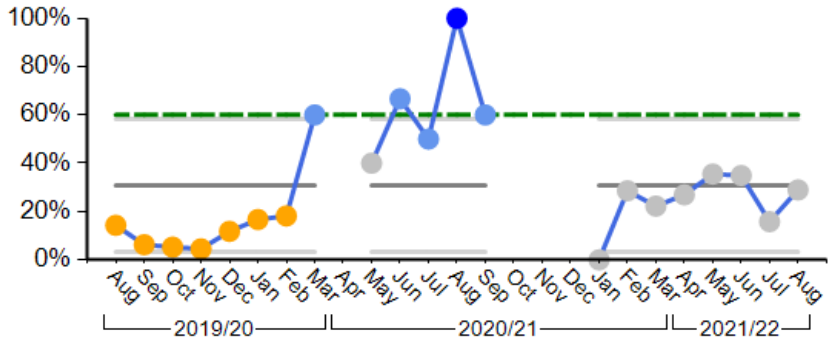
52 Week Waits



Stroke - 90% Stay on Stroke Ward



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



Operations

Cancer

Analyst Narrative:

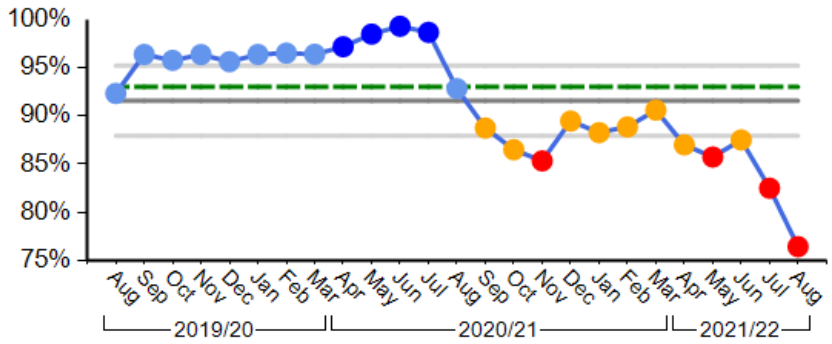
The 14-day GP referral to Outpatients metric continues to show special cause concern and has declined significantly in August to the lowest level for more than 2 years. Similarly, the 62-day GP referral to treatment indicator has declined by over 19% in August and continues to show special cause concern. Although not statistically significant, following 3 months of 100% compliance, the 31-day treatment has declined and has failed to achieve the target in August.

Operational Narrative:

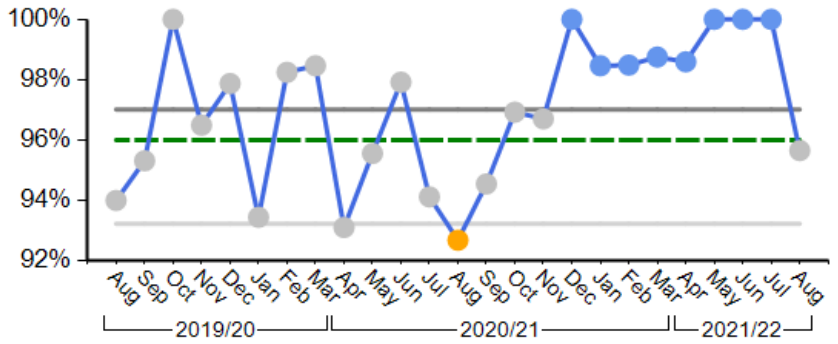
14-day performance continues to be strongly influenced by severe capacity constraints in the endoscopy department for straight to test pathways. However, all sites (except Dermatology) have breached this target in August primarily because of outpatient capacity shortages.
Delays in diagnostic investigations are having a knock-on effect on the speed that cancer patients are treated and so negatively impacting on the 62-day target. Subsequent late referrals to tertiary centres also give us more accountable breaches. All tumour sites (except Upper GI) had patients breaching this target in August, with colorectal performing worse at 0%.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	76.5%	257	Aug 21		93%	82.5%	Jul 21	93%	83.7%	
31 day treatment	96%	95.7%	2	Aug 21		96%	100%	Jul 21	96%	99%	
62 day GP referral to treatment	85%	57.9%	20	Aug 21		85%	77.1%	Jul 21	85%	70.4%	

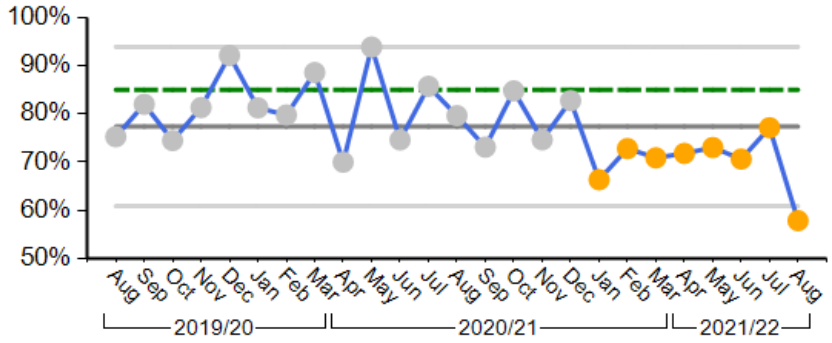
14 day GP referral to Outpatients



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 September. Several indicators are showing special cause improvement this month. Outpatient Slot Utilisation is showing special cause improvement although has declined in September. Despite showing special cause improvement, theatre utilisation on both sites has marginally reduced in September. The A&E Conversion rate is showing special cause improvement and has reduced in September, 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. The number of Stranded and Super-Stranded patients have also increased in September and have breached the target.

Operational Narrative:

SDGH occupancy levels sustained levels in high 90's; patients bedded in ED and CDU overnight.
Significant impact of Ward 11A closure since June 2021 on acute medical flow, flow through AMU significantly impeded by the number of surgical outliers.
Impact of continued essential ward closures with average loss of 7 beds impacting ED occupancy and resulting in a bedded CDU; although the refurbishment paused mid-month.
Walk in attendances at a high with primary care/walk in type patients 75.9% of all attendances in September 21; increase of 0.9% in month.
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 fast-track patients at home; community beds running at near 100%.
Multiple COVID-19 outbreaks in West Lancashire care homes resulting in closure.
Intermittent surges in COVID-19 admissions and several outbreaks on medical and surgical wards resulting in bay closures and paucity of side rooms.
Limited capacity in the Discharge Lounge due Ward 1 being bedded restricts discharge flow and admissions to wards from ED.
The work of the Urgent and Emergency Care Improvement Group continues with an aim to improve flow through the organisation.

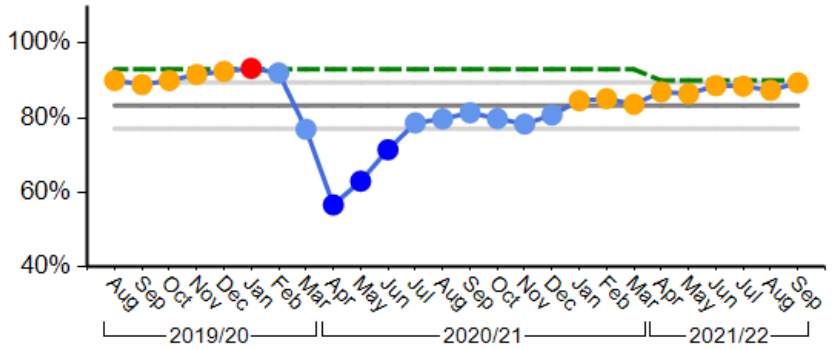
Outpatient Slot Utilisation - Utilisation has dropped slightly this month by 0.9% from the previous month. Overall, we are still maintaining a good position with utilisation across all CBU's, Cancellations of clinics have continued to increase due to reg shortages and sickness which will have impacted on the filling of short notice empty slots. Outpatient Improvement Group will be reviewing all the less than six weeks' notice reasons with all CBU's.

Hospital and patient cancellation rates have both improved although DNA rate has gone up. Work has commenced on the reasons for late starts and there is a noticeable high percentage of consultants arriving after start time of designated lists.

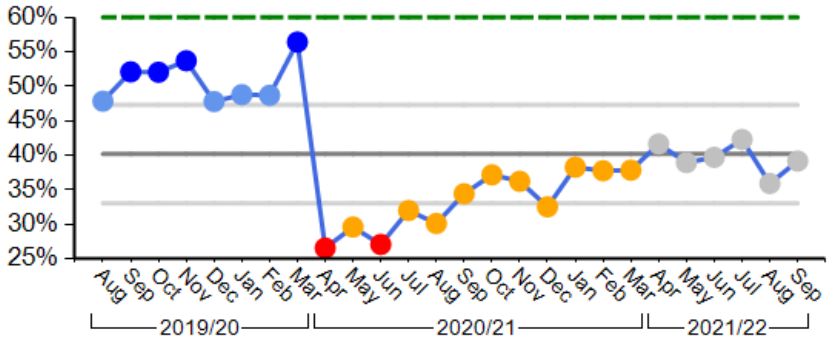
Staff absence remains a challenge in theatres and there is an on-going piece of work to support these members to return to work.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	90%	89.4%	N/A	Sep 21	H	90%	87.4%	Aug 21	90%	87.8%	?
Bed Occupancy - ODGH	60%	39.2%	N/A	Sep 21		60%	35.9%	Aug 21	60%	39.5%	F
Stranded Patients (>6 Days LOS)	163	169	169	Sep 21		163	156	Aug 21	163	929	?
Super Stranded Patients (>20 Days LOS)	53	59	59	Sep 21	L	53	44	Aug 21	53	269	?
OP Slot Utilisation	95%	92.4%	N/A	Sep 21	H	95%	93.3%	Aug 21	95%	93.9%	?
New:Follow Up	2.63	2.2	N/A	Sep 21	L	2.6	2.4	Aug 21	2.63	2.5	?
DNA (Did Not Attend) rate	7%	7.5%	1672	Sep 21		7%	7.1%	Aug 21	7%	6.5%	?
Theatre Utilisation - SDGH	75%	63.3%	N/A	Sep 21	H	75%	68.7%	Aug 21	75%	66.7%	?
Theatre Utilisation - ODGH	75%	69.7%	N/A	Sep 21	H	75%	72.2%	Aug 21	75%	71.1%	?
Southport A&E Conversion Rate	28%	20.1%	1028	Sep 21	L	28%	21.3%	Aug 21	28%	21.3%	?

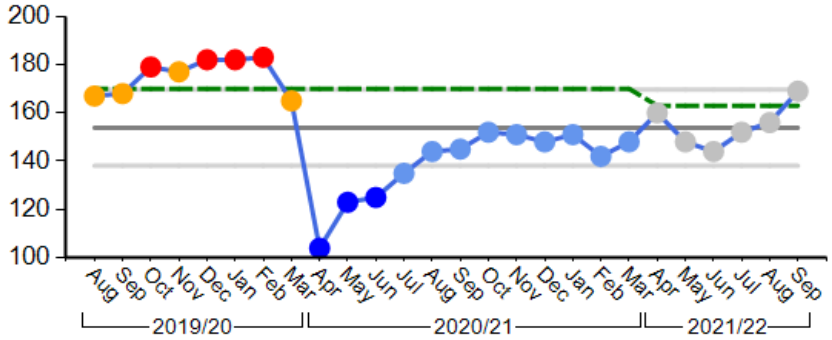
Bed Occupancy - SDGH



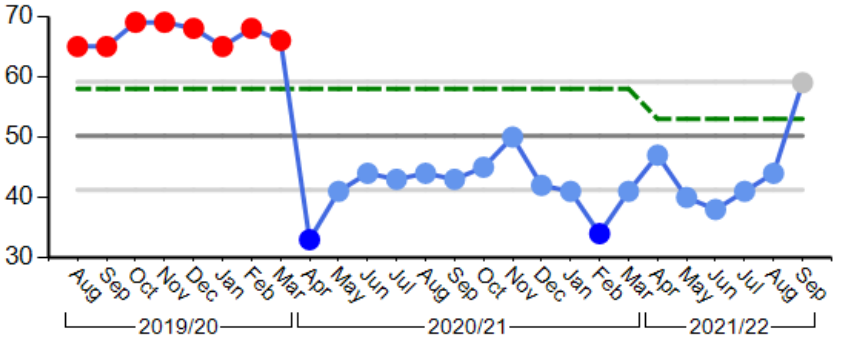
Bed Occupancy - ODGH



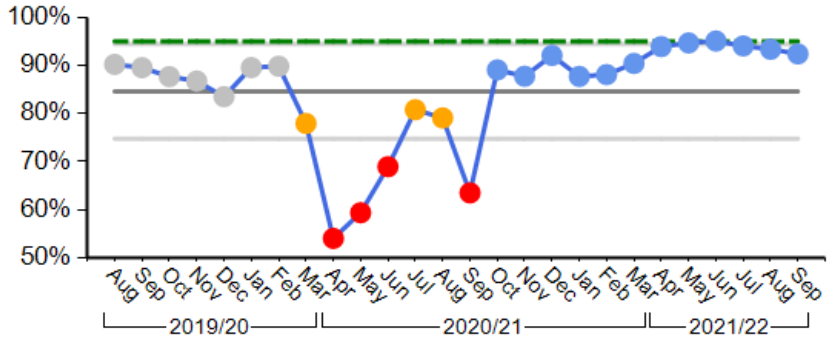
Stranded Patients (>6 Days LOS)



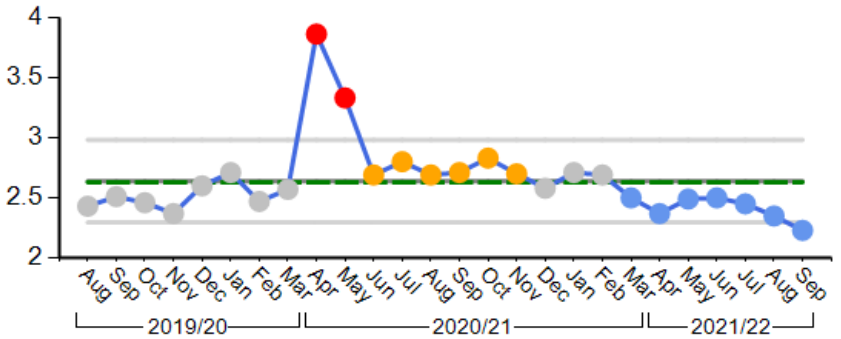
Super Stranded Patients (>20 Days LOS)



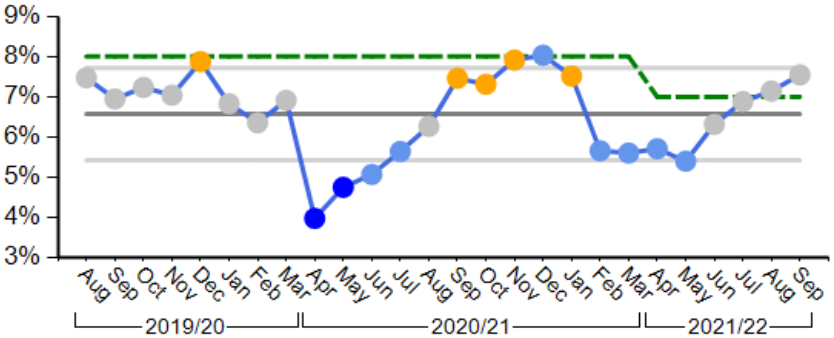
OP Slot Utilisation



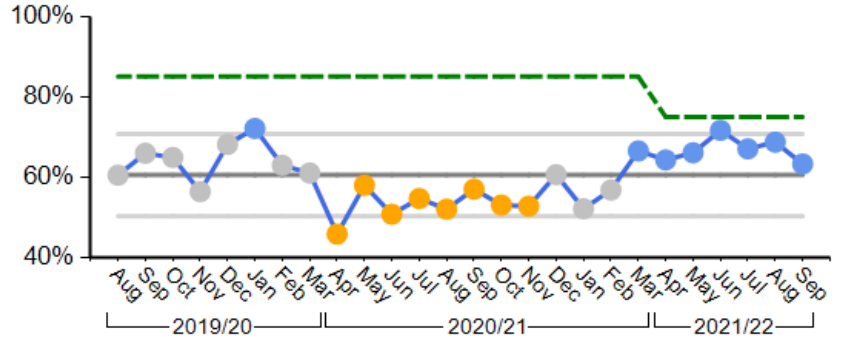
New:Follow Up



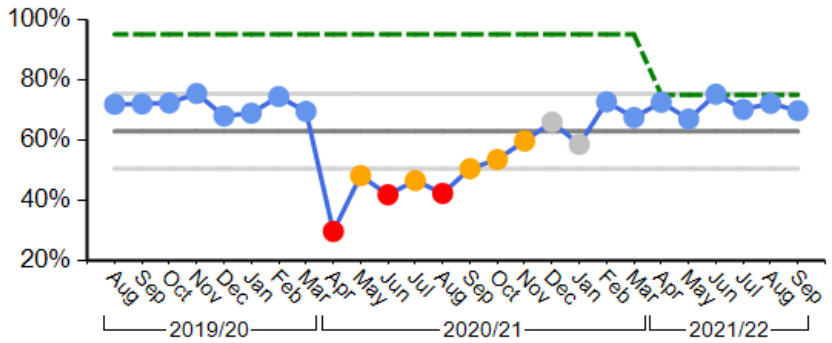
DNA (Did Not Attend) rate



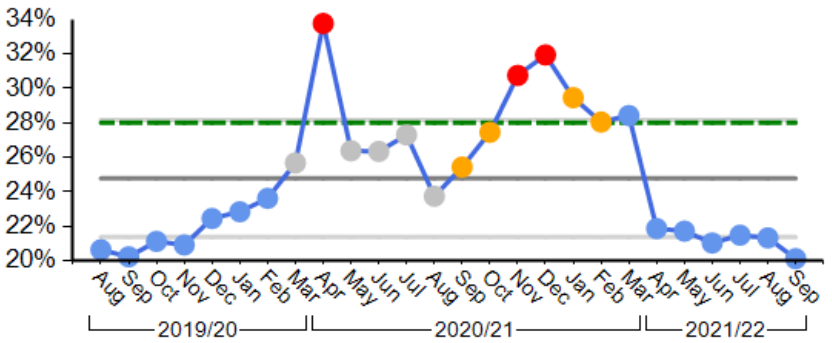
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate



Finance

Finance

Analyst Narrative:

Both the Pay and Non-Pay Run rate metrics are showing special cause concern with increases in September. The I&E surplus or deficit/total revenue, Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn, Agency Staff Run Rate (Cost), % Agency Staff (cost), Capital Spend – Forecast Outturn and Cash Balance are showing special cause improvement.

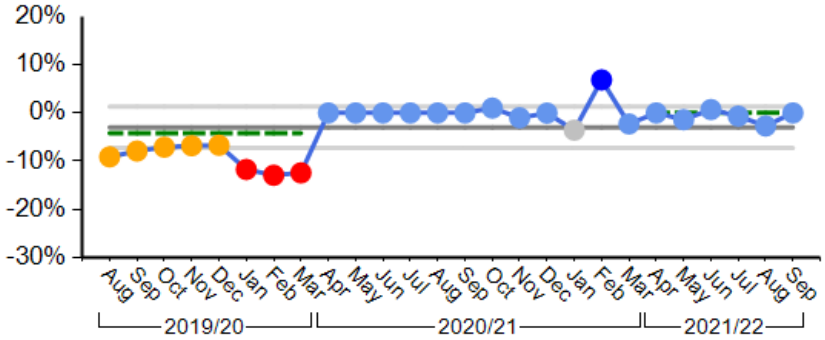
Operational Narrative:

The Trust has achieved financial breakeven for H1 of 2021/22.
Whilst the Trust has delivered the H1 financial plan requirement to break even, this was achieved through:
- Receipt of system funding of £0.5m
- Technical adjustments of £1.0m
The above resulted in a non-recurrent in-month favourable variance, bring the YTD position to back into balance.
The Trust run rate increased during H1 to a c£0.6m in-month deficit by M6 (prior to the above mitigations). The exit run rate for H1 therefore shows a c£3.9m underlying deficit being carried into H2 – noting £nil ERF is currently anticipated at system level under revised rules for H2.
Expenditure Medicine & Emergency Care CBU's adverse variance is mainly driven by temporary staffing expenditure
Planned Care and Specialist & Support Services CBUs are moving closer towards financial balance – with opportunities identified in H2 to bridge this position.
CIP – The Trust has transacted schemes totalling £2.2m including £1.4m of 'technical schemes' (areas of underspend identified cross CBUs) versus the H1 target of £3.7m.
CBUs are being supported to review underspending cost centres in order to consider any areas which could contribute to CIP delivery on a recurrent or non-recurrent basis.
This will ensure CIP is appropriately reflected – and enable clear line of sight of financial pressures in order to address the true drivers behind financial performance.
Cash The cash balance at the end of September was £1.6m versus an original plan of £4.7m. The main driver is the Trust improving its Better Payment Practice Code (BPPC) performance.
Pending finalisation of H2 plans, and subject to notification of final system envelopes the Trust is anticipating requiring external cash support from January 2022 (via the existing DHSC revenue loan route).
H2 cash flow forecasts indicate this requirement to be c£7.5m, based on an anticipated of £5.5m in H2, and £2m working capital movements to improve BPPC.
FP&I Committee will be kept updated on the cash position - noting authorisation will be required by Board in advance of drawing DHSC cash support for Q4.
BPPC – The Trust's recovery plan submitted to NHSEI set out an improvement trajectory to achieve 95% on a monthly basis by the end of March 2022. The Trust has achieved 95.94% in month in September.
The cumulative percentage now stands at 85.8% - a significant turnaround from 65.9% at the end of July.
Capital - Year to date investment to the end of September of £1.5m (£0.7m in-month) versus a £6.1m capital programme for 2021/22.
Actual spend to for H1 represents 23.8% of the annual budget.
Work is ongoing re the development of 2022/23 capital requirements.

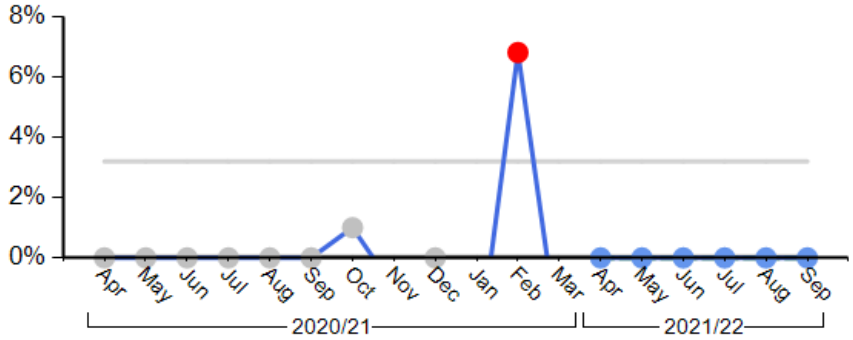
	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	0%	0%	N/A	Sep 21		0%	-2.7%	Aug 21	0%	-0.86%	
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	0%	N/A	Sep 21		0%	0%	Aug 21	0%	0%	

Pay Run Rate - Trust		£14687K	N/A	Sep 21	H	£13,400K	£13328K	Aug 21	£82,200K	£81,715K	?
Non Pay Run Rate - Trust		£6200K	N/A	Sep 21	H	£6,000K	£6160K	Aug 21	£35,650K	£35,960K	?
Year to date Budget in balance		Yes	N/A	Sep 21			No	Aug 21		Yes	?
Budget in balance - forecast year end		Yes	N/A	Sep 21			Yes	Aug 21		Yes	?
Bank & Agency Run Rate - Trust		£2284K	N/A	Sep 21			£2411K	Aug 21		£13,300K	?
Bank & Agency Staff Run Rate (%)		15.6%	N/A	Sep 21			18.1%	Aug 21		16.6%	?
Agency Staff Run Rate (Cost)		£720K	N/A	Sep 21	L		£650K	Aug 21		£4,000K	?
% Agency Staff (cost)		4.9%	N/A	Sep 21	L		4.9%	Aug 21		6.0%	?
Year To Date Reduction in Premium Rate pay		-£100K	N/A	Sep 21			£200K	Aug 21		-£100K	?
CIP – Performance against Plan		£800K	N/A	Sep 21		£600K	£500K	Aug 21	£3,700K	£2,200K	?
CIP – Forecast Outturn		£4400K	N/A	Sep 21		£7,400K	£4400K	Aug 21	£7,400K	£4,400K	?
CIP on Target		No	N/A	Sep 21			No	Aug 21		No	?
Capital Spend – Actual in Month		£700K	N/A	Sep 21		£500K	£200K	Aug 21	£3,400K	£1,500K	?
Capital Spend – Forecast Outturn		£6100K	N/A	Sep 21	L		£6900K	Aug 21			?
Cash Balance		£1600K	N/A	Sep 21	L		£3400K	Aug 21			?

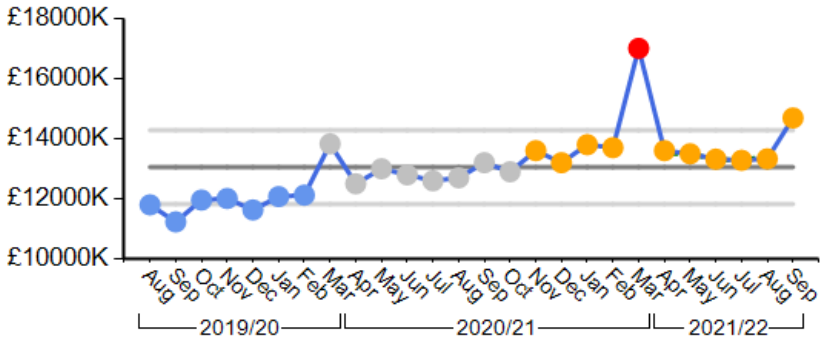
I&E surplus or deficit/total revenue



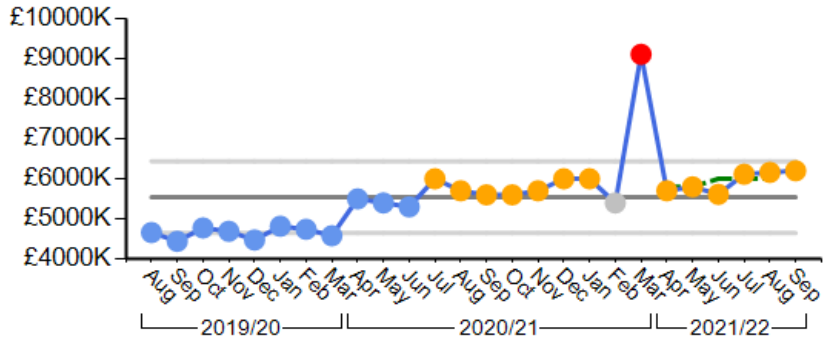
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



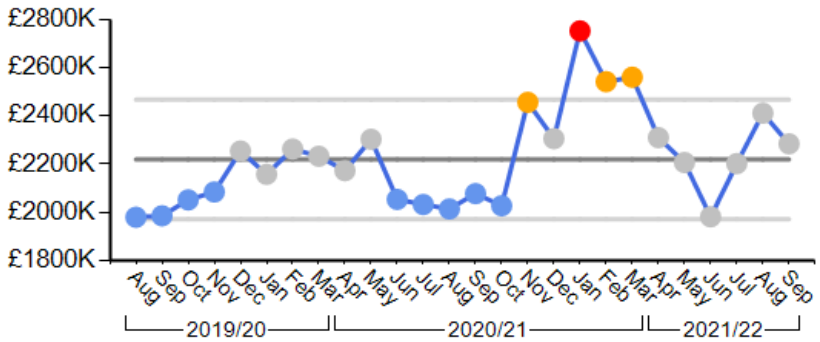
Pay Run Rate - Trust



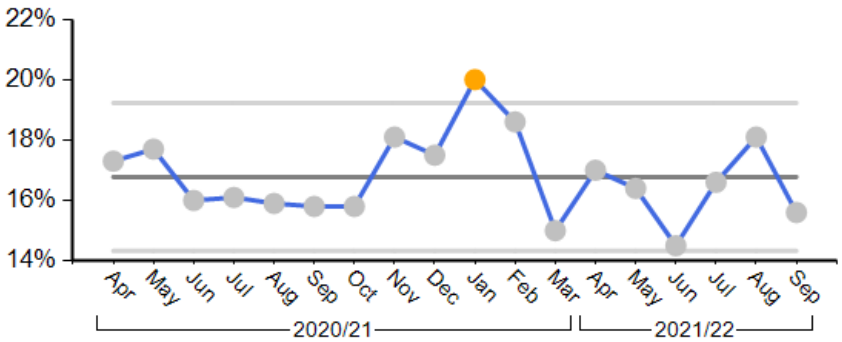
Non Pay Run Rate - Trust



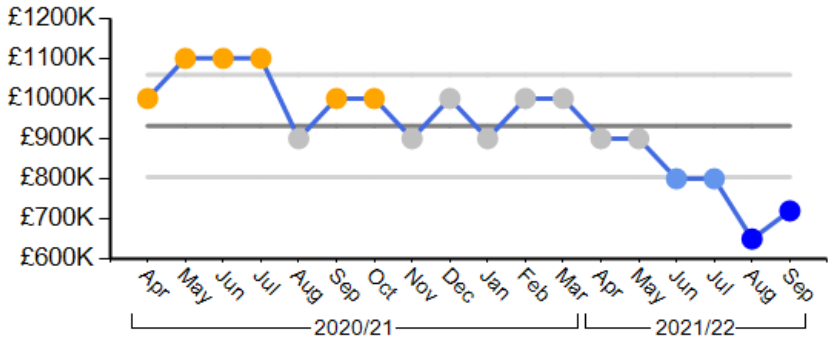
Bank & Agency Run Rate - Trust



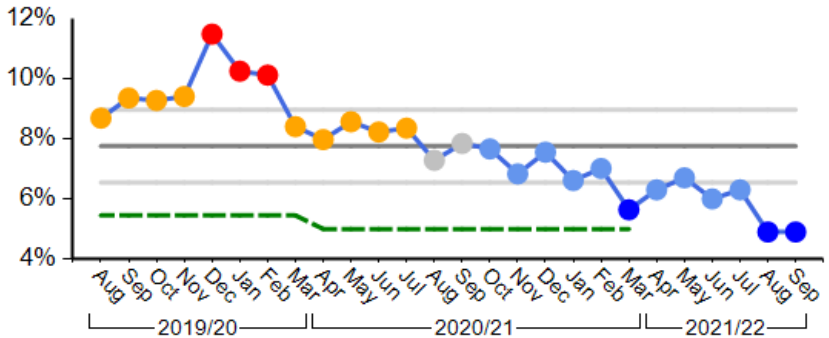
Bank & Agency Staff Run Rate (%)



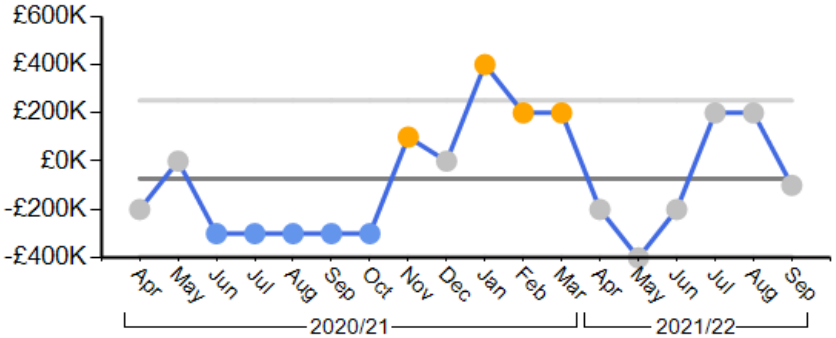
Agency Staff Run Rate (Cost)



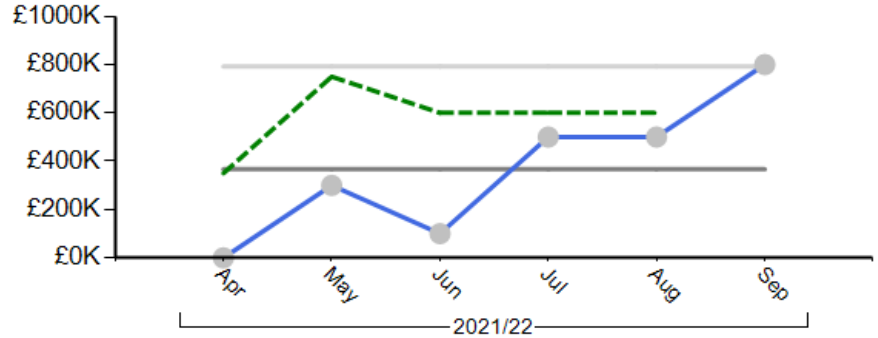
% Agency Staff (cost)



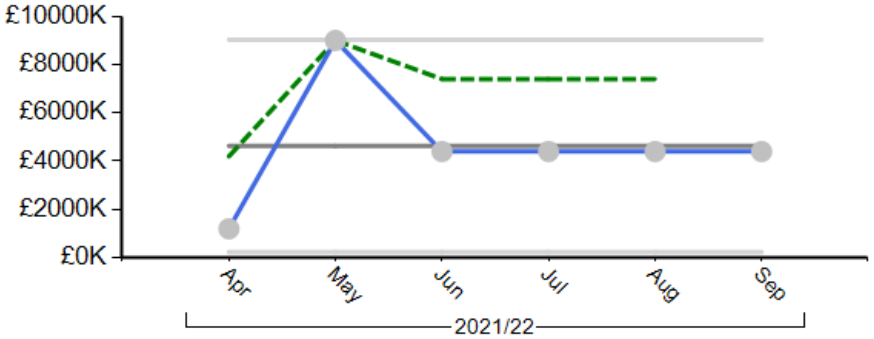
Year To Date Reduction in Premium Rate pay



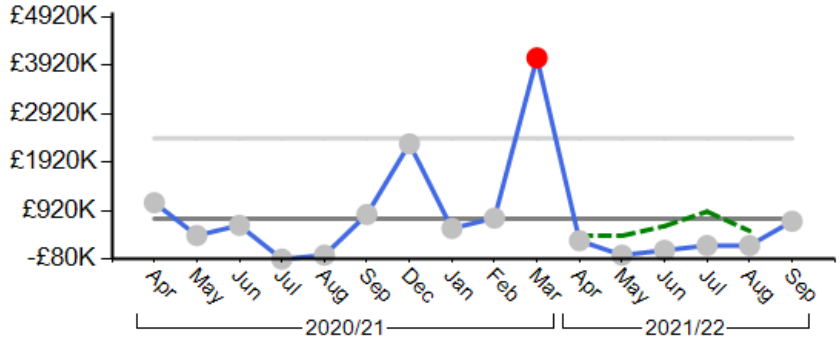
CIP – Performance against Plan



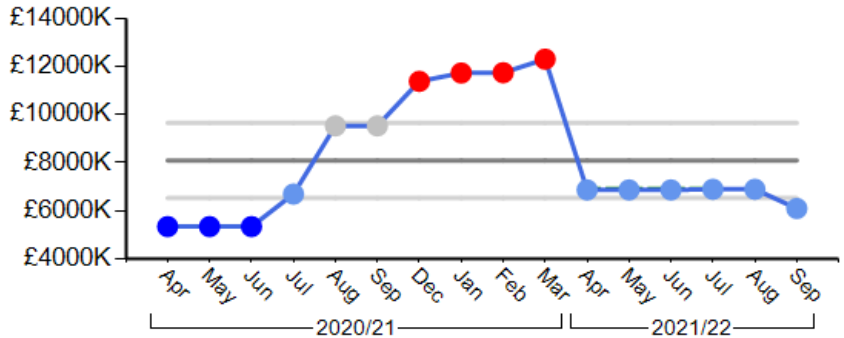
CIP – Forecast Outturn



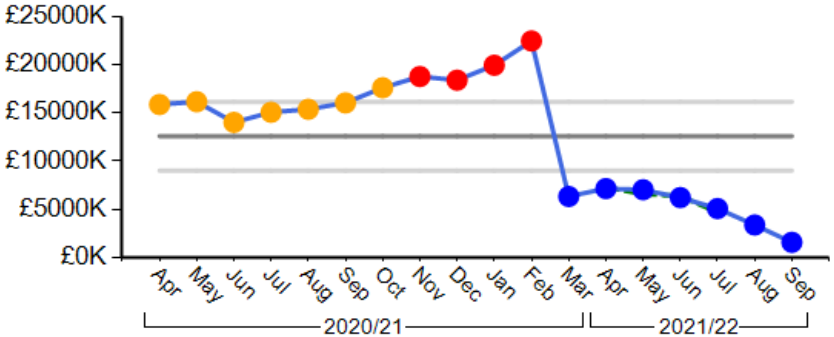
Capital Spend – Actual in Month



Capital Spend – Forecast Outturn



Cash Balance



Alert, Advise, Assure (AAA)
Highlight Report

Committee/Group Meeting date:	Workforce Committee 26 October 2021
Lead:	Lisa Knight

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

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, as well as seasonal colds and respiratory infections. The Workforce Directorate are continuing to focus on the health and wellbeing of staff to support their attendance.

Staff Turnover

Whilst the staff turnover rate has decreased in month from 1.7% in August 2021 to 1.2%, the 0.75% target is still not being met and the rolling staff turnover rate has increased. This indicator is still a cause for concern for the organisation.

Staff Retention

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

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

PDRs

Compliance in PDRs has increased from 78.6.% in August 2021 to 79.5% in month, however the desired target of 85% is still not being met. The Estates and Facilities CBU improved by 22.73% in month which is extremely positive; as well as improvement of 20.17% in Corporate Services compliance in month. There is however mixed pictures for the CBUs.

Nursing Vacancies

The nursing vacancy rate has remained static in month. International recruitment is continuing to bring nurses into the organisation: 106 are in the country; 81 of these have passed their OSCEs and 14 are waiting for their Pins.

Bank and Agency

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

Undergraduate Deans Visit update

The Committee were informed of the issues identified by the University of Liverpool during their Undergraduate Dean's Visit, and what actions are being taken to address them. Whilst it was clear there are issues with this area of work, it was noted how much effort is being undertaken to address the concerns.

ASSURE

(Detail here any areas of assurance that the committee has received)

Medical Vacancies

Whilst the vacancies for medical staff have increased from 6.9% in August 2021 to 8.6% in month, there are still a number of successes: there are 30 medical posts under offer; two Trust locums for Radiology have been appointed; and there are 3 candidates for the Acute Medicine posts. An increased engagement from medics are starting to turn medical recruitment around positively.

Mandatory Training
Whilst Mandatory Training compliance has decreased in month to 88.8% from 88% in August 2021, the metric has again exceeded the current planned target.

Time to Hire
Time to hire has decreased in month from 59 to 58 days.

Band 5 Nurse Vacancies
The trajectory is that the Trust will fill all Band 5 inpatient nursing vacancies by the end of 2021.

Workforce Equality Monitoring 2020-21 Report
The Committee were informed that the report is reflective of the community the hospital serves and that the Trust needs to do more in terms of protective characteristics to support attendance.

Gender Pay Report 2020 -21
Whilst the mean average gender pay gap has improved compared to 2019 data, there are lots of opportunities to try and narrow this gap which the Equality, Diversity and Inclusion lead will be working on. It was agreed for the Trust to liaise with StHK on support to build up Staff Networks.

Apprenticeships
A presentation on Apprenticeships was provided to the Committee and received very well. Whilst there is a funding risk issue, the Apprenticeship lead is ensuring there are measures in place to mitigate it.

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)

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO025/21**	**FOI Exempt**	**NO**
Report Title	**GENDER PAY REPORT 2020-21**		
Executive Lead	Jane Royds: Director of Human Resources and OD		
Lead Officer	Bob Davies: Equality Lead		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides an update the Committee on the findings of the Gender Pay Gap analysis which all organisations (with over 250 employees) are required to undertake and publish by the October 2021.

Executive Summary

Gender Pay Gap reporting key themes for the Trust

- The Trust workforce is **78.95% female** and **21.05% male**
- The Trust Medical & Dental workforce is **62.20% male** and **37.80% female**
- As at March 2020 the Trust has a **21.72%** mean average gender pay gap with females earning **£4.38 an hour less** than males (compared to a current sector mean **18.9%**)
- The mean average gender pay gap in 2020 has improved in comparison with 2019 data when as at 31st March 2019 females earned **£5.14** an hour less than males with an **25.12%** mean average gender pay gap
- As at March 2020 the Trust has a **5.62%** median hourly rate gender pay gap with females earning **0.86p an hour less** than males.
- The median gender pay gap in 2020 has improved as at 31 March 2019 females earned **£1.14 an hour less** than males with a **7.6%** median
- Bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce being awarded a clinical excellence award is male at **62.20%** compared to **37.80%** female
- Benchmarking NHS Trust information relating to the 31 March 2020 data is not yet fully available due to the deadline of reporting being October 2021. However, a comparison will be undertaken once the March 2020 data for our Northwest peer group is available, and any subsequent actions will be incorporated into the 2021-22 action plan.

What next

The Trust has developed a Gender Pay Gap Action Plan with the aim of reducing the gender pay gap by working in partnership with a diverse group of staff to ensure we obtain a broader set of views on how we address the issues.

The action plan will be monitored and updated, updates will be provided to the various Trust groups / committees and the report and updates are also a requirement of the equality section of the quality contract with the CCG's.

The Trust will promote the Trust's Our People Plan that references flexible working, the trust will aim to ensure all staff are aware of the opportunity to request flexible working,

The trust will promote coaching, mentoring opportunities, and interventions to support the talent development of women in the workplace, including targeted mentoring and coaching programmes.

The current recruitment process will be reviewed, and the trust will work in partnership with a diverse group of staff to develop and improve the current process.

Staff networks will continue to be promoted to staff across the trust and members will be encouraged to be actively involved in various trust groups and committees, there will also be an opportunity for staff to highlight their lived experience to trust staff.

Training and development opportunities will be promoted across the trust and unconscious bias and cultural awareness will also be made available.

The Trust will set up a Carers Network Group working in partnership with external carer organisations who can provide advice and guidance and signpost staff to external organisations who could support them with their caring responsibilities, it is a known fact females are more likely to have carer responsibilities, and this can impact on career progression.

Information from various sources highlights that female staff are predominately the carers for children and older family members which results in taking career breaks The **Social Market Foundation's** report points out that the more hours of care a person provides, the more likely they are to reduce their hours of work or exit the workforce altogether. The Trust must work with staff to support their health and wellbeing and work life balance i.e., flexible working

Benchmark against other Trusts?
31st March 2020 data is not yet fully available due to the deadline of reporting being October 2021. However, a comparison will be undertaken once the March 2020 data for our Northwest peer group is available.

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

Gender Pay Gap Report 2021
Southport and Ormskirk Hospital NHS Trust (SOHT)

Introduction:
The purpose of this report is to update the Board on the findings of the Gender Pay Gap analysis which all organisations (with over 250 employees) are required to undertake and publish by the October 2021.

Southport and Ormskirk Hospital NHS Trust value our staff and the contribution they make and are committed to fair pay irrespective of gender and aim to create a working environment where there are equal opportunities for all our staff so they can fulfil their potential and contribute to our aim of providing the high-quality personal care to patients. We see this as a perfect fit with the Trust SCOPE values.

Supportive
Caring
Open and honest
Professional
Efficient

Gender pay gap reporting is a crucial step to better understand the Trust's position and the broader factors which contribute to pay disparity.

The median and mean pay gaps are calculated using the calculations set out in the gender pay gap reporting regulations: -

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

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

The gender pay gap should not be confused with unequal pay. Unequal pay is the unlawful practice of paying men and women differently for performing the same or similar work or work of equal value; whereas the gender pay gap is a measure of the difference between the average hourly earnings of men and women.

If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help us to identify what those issues are and will support and encourage action. At SOHT employees' terms and conditions of employment are dictated by national agreements, that is: Agenda for Change, Medical and Dental T&Cs and we have a small number of ungraded senior manager contracts. Our Job Evaluation process enables jobs to be

matched to national job profiles and assists us in evaluating jobs locally to determine in which pay band a post should sit. This ensures our pay is fair and appropriate.

Historically 80% of the NHS workforce are women, with more women employed in the lower banded jobs and more men employed in the higher paid Medical and Dental professions. This can have an adverse effect on the average pay figures.

Table of definitions

Mean gap	The difference between the mean * hourly rate of pay of men and women *average pay for all men and average for all women employees
Median gap	The difference between the median * hourly rate of pay of men and women * middle value of pay for all men and middle value for all women employees
Mean bonus gap	The difference between the mean * bonus paid to men and women *average bonus for all men and average for all women employees
Median bonus gap	The difference between the median bonus pay paid to men and women *middle values of bonuses paid to all men compared to all women employees
Bonus proportions (Clinical excellence awards)	The proportions of men who were paid a bonus and women paid a bonus
Quartile bands	The proportions of men and women in the lower; lower middle; upper middle; and upper quartile pay bands *Calculated as 25% of staff in each quartile*

Gender Pay Gap Reporting Key themes for the Trust

- The Trust workforce is **78.95% female** and **21.05% male**
- The Trust Medical & Dental workforce is **62.20% male** and **37.80% female**
- As at March 2020 the Trust has a **21.72%** mean average gender pay gap with females earning **£4.38 an hour less** than males (compared to a current sector mean 18.9%)
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- Bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce being awarded a clinical excellence award is male at **62.20%** compared to **37.80%** female

NHS Gender Pay Gap and Bonus Pay Summary 01/04/2019 to 31/03/2020

Benchmarking:

NHS Trust information relating to the 31st March 2020 data is not yet fully available due to the deadline of reporting being October 2021. However, a comparison will be undertaken once the March 2020 data for our Northwest peer group is available, and any subsequent actions will be incorporated into the 2021-22 action plan.

Trust Workforce:

The Trust employed 3111 staff in a variety of roles on the 31st of March 2020 and this report was compiled in August 2021. The Gender Pay Gap information is based on electronic staff records (ESR) 2020.

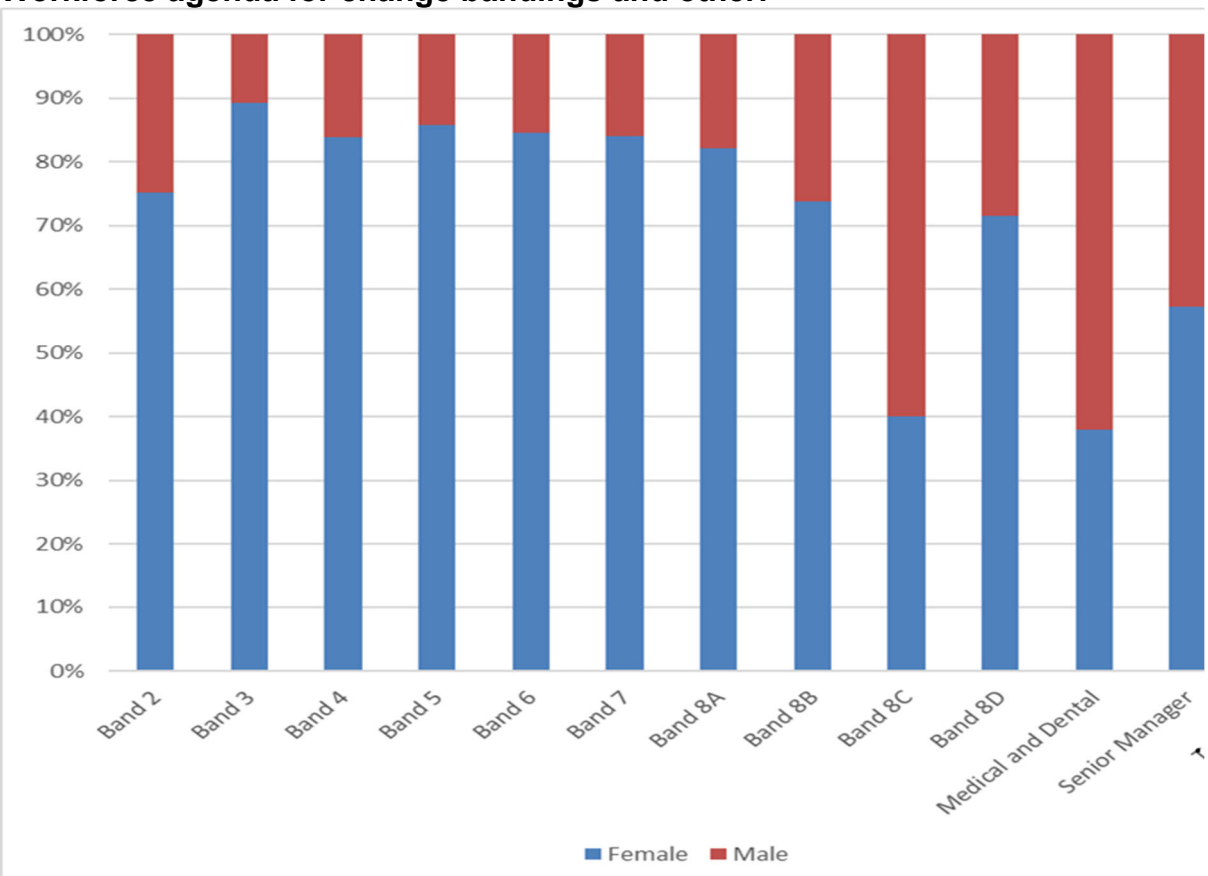
Trust workforce data female - male

Gender	Workforce Numbers	Percentage of workforce
Female	2456	78.95%
Male	655	21.05%
Total	3111	100%

Pay Band & Scales

Pay Band & Scales			
Pay Band /Scale	**Female**	**Male**	**Total**
Band 1	0	0	0
Band 2	551	183	734
Band 3	356	43	399
Band 4	208	40	248
Band 5	498	83	581
Band 6	408	75	483
Band 7	227	43	270
Band 8A	73	16	89
Band 8B	31	11	42
Band 8C	2	3	5
Band 8D	5	2	7
Band 9	0	0	0
Medical	93	152	245
Senior Manager	4	3	7
Grand Total	**2456**	**654**	**3110**

Workforce agenda for change bandings and other:



Percentage % of male and female employees in each pay quartile
This calculation requires an employer to show the proportions of male and female full-pay relevant employees in four quartile pay bands. All employees are placed into the cumulative order according to their pay which is undertaken by dividing the workforce into 4 equal parts.

To create the quartile information all staff are sorted by their hourly rate of pay, then this is split into four equal parts. When reviewing the quartile information, it is important to take into account the types of roles available within the organisation and the different gender splits that will occur within specific roles. There is a higher number of females in the lower quartile; included in this are admin and ancillary staff groups that have a higher proportion of female staff which is reflected in the calculation. The upper quartile has a higher proportion of female staff, in all bands from 2- 9 in the Trust there is a higher number of female staff.

Proportion of men and woman in each pay quartile = (total number of males and females in each pay quartile)

Quartile	Female		Male		Female %		Male %	
	2020	2019	2020	2019	2020	2019	2020	2019
1	589	539	163	149	78.32%	78.34%	21.68%	21.66%
2	612	619	144	124	80.95%	83.31%	19.05%	16.69%
3	629	589	126	126	83.31%	82.38%	16.69%	17.62%
4	535	498	220	218	70.86%	69.55%	29.14%	30.45%

The mean gender pay gap: shows the difference in average hourly pay between men and women, to calculate the mean or average, add up all the hourly pay rates and divide by the number of staff.

The table below shows the mean hourly rate for a male is £20.15 compared to £15.77 for female members of staff as of 31st March 2020 a pay gap of 21.72% the figure for 2019 was 25.12% = **3.40% decrease**.

The Mean average hourly rate

Gender	Mean Avg. Hourly Rate £		
	2020	**2019**	**Difference**
Male	£20.15	£20.46	- 0.31
Female	£15.77	£15.32	+0.45
Difference	£ 4.38	£ 5.14	-0.76
Pay Gap %	21.72%	25.12%	**- 3.40%**

The median gender pay gap: is the difference between the median (mid-point) hourly rate for male employees and the median hourly rate for female employees, to calculate the median: rank the hourly rate from high to low and take the midpoint.

The table below shows the median hourly rate for a male is £15.36 compared to £14.50 for female staff members, this shows an average pay gap of 5.62%, the figure for 2019 was 7.60% there has been a **decrease of 1.98%** in 2020.

The Median average hourly rate

Gender	Median Avg. Hourly Rate £		
	2020	**2019**	**Difference**
Male	£15.36	£15.06	+0.30
Female	£14.50	£13.91	+0.59
Difference	0.86p	£ 1.14	+0.28
Pay Gap %	5.62%	7.6%	-1.98%

Mean average and the median bonus pay received in the last 12 months

Alongside ordinary rates of pay, we are also required to report on bonus payments. Clinical excellence awards exist to recognise and reward the contribution of NHS consultants, over and above that normally expected in their role. Awards are dependent on merit and not seniority or age. Clinical excellence awards for medical staff are the only payment identified within the ESR standard report

Clinical Excellence Awards: Number of staff eligible 2019-20: = 30

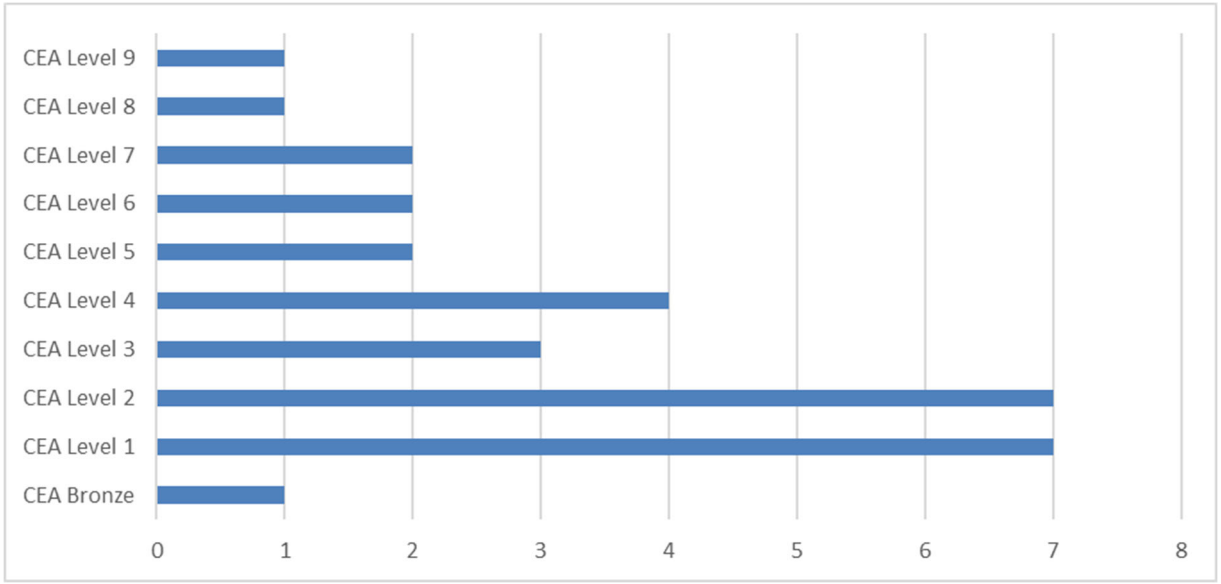
Gender	Employees Paid Bonus		Total Relevant Employees		Percentage%		
	2020	2019	2020	2019	2020	2019	Difference
Male	25	27	655	626	3.81%	4.31%	- 0.5%
Female	5	6	2456	2314	0.20%	0.25%	- 0.05%
Totals	30	33	3111	2940			

The data in tables below relates to clinical excellence awards for medical staff as this is the only payment identified within the ESR standard report.

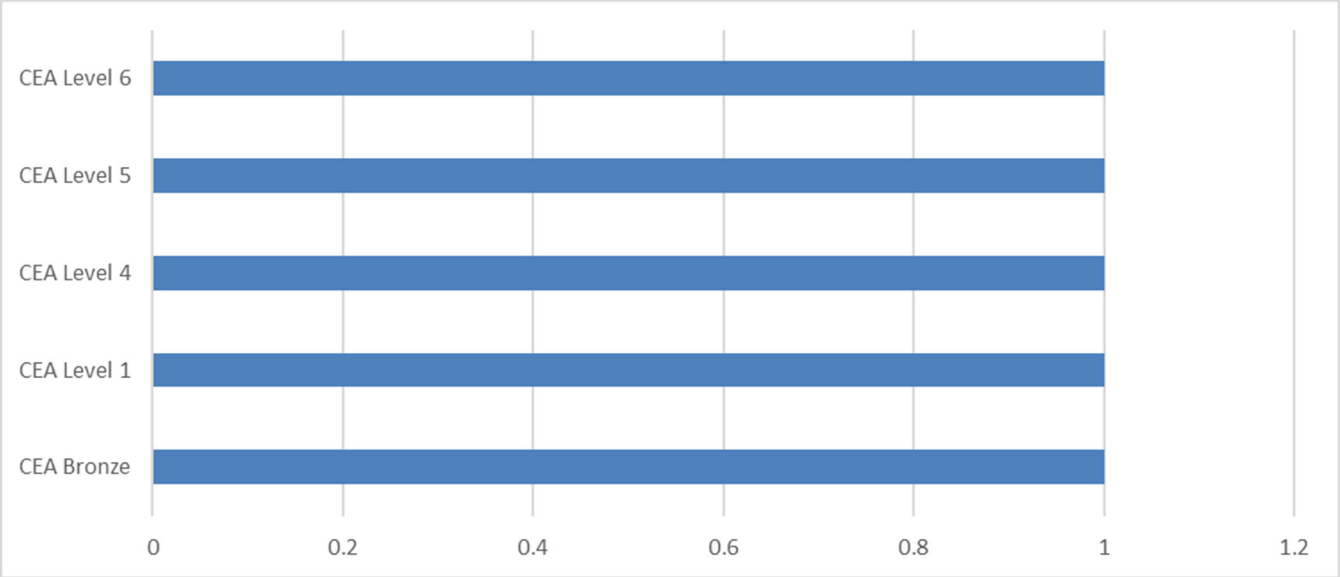
The Mean average and median hourly rates:

Gender	Mean. Pay		Median Pay	
	2020	2019	2020	2019
Male	£10,815.57	£11,136.97	£6,032.04	£6032.04
Female	£16,889.59	£12,818.02	£15,080.04	£11,310.03
Difference	-£ 6,074.02	-£ 1,681.04	-£ 9048.00	£5277.99
Pay Gap %	-56.16%	-15.09%	-150.00%	-87.50%

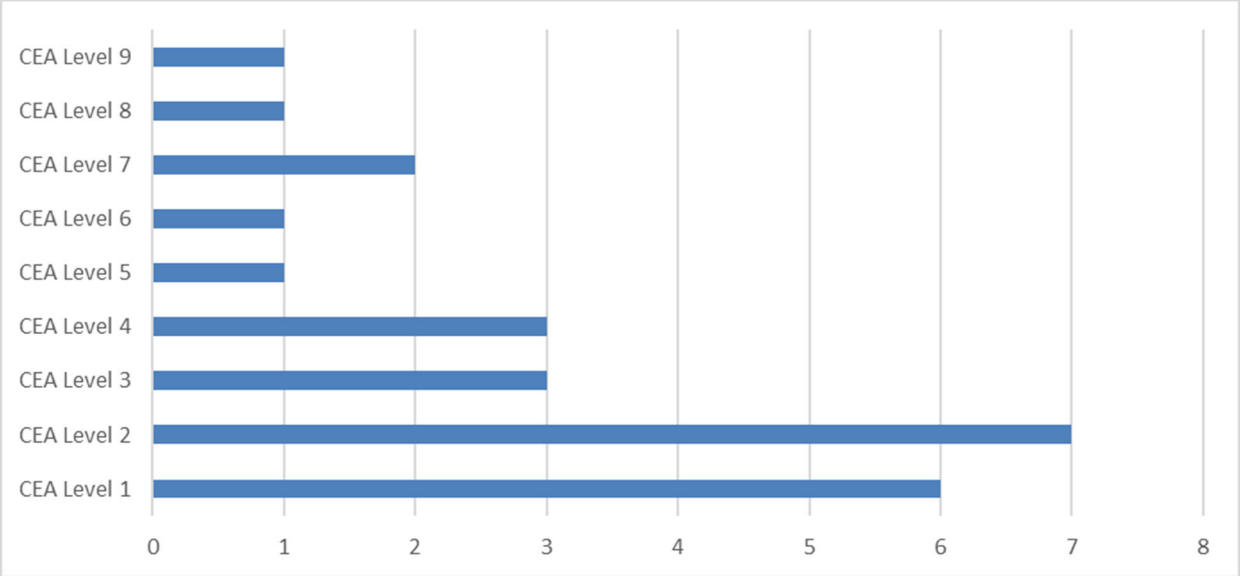
Total Clinical Excellence Awards = 30 in total to 25 Male and 5 Female Staff various levels



Total Clinical Excellence Awards – Female = 5



Total Clinical Excellence Awards – Male = 25



Medical Dental and other workforce

Of the medical and dental workforce	**Male %**		**Female %**	
	2020	2019	2020	2019
	62.20%	63.00%	37.80%	37.00%
Remainder of workforce	**Male%**		**Female%**	
	21.05%	17.12%	78.95%	82.88%

Summary of Results
For the majority of staff at Southport & Ormskirk Hospital Trust salaries are determined through a job evaluation scheme called Agenda for Change (AfC), as are all NHS Trusts. Job evaluation process evaluates the job and not the post holder and makes no reference to gender, or any other protected characteristic, of existing or potential job holders.

As at March 2020 the Trust has a **21.72%** mean average gender pay gap compared to a current sector mean **18.9%** = **2.82% above** current sector average.

The mean average gender pay gap in 2020 has improved in comparison with 2019 data when it was **25.12%**, this is a **3.4%** improvement

As at March 2020 the Trust has a **5.62%** median hourly rate gender pay gap compared to 2019 when it was **7.6%,** this is a **1.98%** improvement.

Changes to the proportion of men and woman in each pay quartile:
Female staff: The figures below show an increase in females in Quartile1,3 and 4 and a decrease in Quartile 2.

Male staff: The information below shows a small increase in males in the Quartile 1,2 and 4 in Quartile 3 male figures stayed the same.

Quartile	Female		Male	
	2020	**Increase in 2020**	**2020**	**Increase 2020**
1	589	50 Increase	163	14 Increase
2	612	7 Decrease	144	20 Increase
3	629	40 Increase	126	Same
4	535	37 Increase	220	2 Increase

Bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce being awarded a clinical excellence award is male at **62.20%** compared to **37.80%** female

Benchmarking NHS Trust information relating to the 31st March 2020 data is not yet fully available due to the deadline of reporting being October 2021. However, a comparison will be undertaken once the March 2020 data for our Northwest peer group

is available, and any subsequent actions will be incorporated into the 2021-22 action plan.

Work on closing the gender pay gap

The Trust's positive inclusive approach towards equal opportunities will aim to ensure that both genders will be treated equally.

Our options for employment flexibility are open to all staff and are not driven by gender. We will further promote the Trust's Our People Plan that references agile and flexible working, the trust will aim to ensure all staff are aware of the opportunity to request flexible working,

The trust will promote coaching and mentoring opportunities and interventions on offer to support the talent development of women in the workplace, including targeted mentoring and coaching programmes.

The current recruitment process will be reviewed, and the trust will work in partnership with staff to develop and improve the current process.

Staff networks will continue to be promoted to staff across the trust and members will be encouraged to be actively involved in various trust groups and committee, there will also be an opportunity for staff to highlight their lived experience to trust staff.

Training and development opportunities will be promoted across the trust and unconscious bias and cultural awareness will also be made available.

Gender pay gap report action plan: Appendix 1

APPENDIX 1

Southport and Ormskirk Hospital NHS Trust

Equality Diversity & Inclusion: Gender - Gender Pay Gap

Employers in the NHS should	Outcomes we seek to achieve	Action to achieve	Named Person /Team & Date
Action 1: Ensure ESMs own the agenda, as part of culture changes in organisations, with improvements in gender representation in various roles and gender pay as part of objectives and appraisal by: a) Setting specific KPIs and targets linked to recruitment. b) KPIs and targets must be time limited, specific and linked to incentives or sanctions	To reduce/eliminate impact of unconscious bias during interviews to increase likelihood of appointing candidates from diverse backgrounds to post	**Equality Monitoring** Improve staff equality monitoring reporting on ESR, seek guidance from staff networks and partners **Unconscious Bias & Cultural Awareness Training:** The Trust will target the training at frequent interview panel chairs and members, in the first instance. **Review the gender profile of shortlisting to appointment indicator:** The Trust will monitor gender data to monitor the relative likelihood of staff being appointed from shortlisting across all posts *Note: This refers to both external and internal posts on a bi-monthly basis and updates will be provided to various Trust committees*	**June 2021 - Ongoing** **July 2021 -Ongoing** **September 2021 - Ongoing** • ED&I Lead • Recruitment Team • Resourcing Team • Staff Networks

Action 2: Introduce a system of 'comply or explain' to ensure fairness during interviews This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair	To increase diversity of talent pools in order to increase likelihood of appointing candidates from diverse backgrounds to post	**Staff Network Members** Seek the view of Staff Network members / staff groups on how the Trust can develop the interview process, listen and act on the lived experiences of the process **Unconscious Bias & Cultural Awareness Training:** The Trust will target the training at frequent interview panel chairs and members **Staff Workshops** Run a workshop with staff from underrepresented groups to review the entire R&S process, and identify improvements and enhancements (particularly ideas for positive action such as agreeing a statement for all job adverts)	**September 2021 - Ongoing** • ED&I Lead • Recruitment Team • Staff Networks **November 2021 - Ongoing** • ED&I Lead • Education Team • Recruitment Team **January 2021 - Ongoing** • ED&I Lead • Education Team • Recruitment Team • Staff Networks
Action 3: Organise talent panels to: **a)** Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments	To embed accountability and make workforce diversity an organisational priority in order to increase likelihood of appointing candidates from diverse backgrounds to post	**Career Pathways: Work with staff** to improve career development, job satisfaction and support individuals to learn new skills and take on extra responsibilities that enable them to progress within the organisation.	**October 2021 - March 2022** • HR Senior Business Partner • O/D team • Education Team • Staff networks • Recruitment team

must be advertised to all staff **b)** Agree positive action approaches to filling roles for gender groups **c)** Set transparent minimum criteria for candidate selection into talent pools		Set up a woman's staff network group and consider this group as a pilot to developing career development support, such as career coaching	
Action 4: Enhance EDI support available to: **a)** Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies **b)** Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews.	To make workforce diversity an organisational priority in order to increase likelihood of appointing candidates from diverse backgrounds to post	**Equality Impact Assessment (EIA)Training:** The Trust will target the training at frequent interview panel chairs and members **Person Specification for Trust vacancies:** All Trust person specifications for 8a roles and above to have ED&I on the person specification **Demonstration of ED&I work / legacy to be part the interview panels questions:** 8a roles and above to evidence base how they have embedded ED&I in their working environments **Staff Network Members** Seek the views of Staff Network members / staff groups on the Recruitment & Selection Policy	**January 2021 - Ongoing** • ED&I Lead • Recruitment Team • OD Team • Training & Development Team **October 2021 - Ongoing** • ED&I Lead • HR • Recruitment Team **November 2021 - Ongoing** • ED&I Lead • Recruitment Team **January 2021 - Ongoing** • ED&I Lead • Education Team • Recruitment Team

Action 5: Overhaul interview processes to incorporate: **a)** Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. **b)** Ensure adoption of values-based shortlisting and interview approach **c)** Consider skills-based assessment such as using scenarios.	To close/reduce inequality gaps during interviews to increase likelihood of appointing candidates from diverse backgrounds to post	**Unconscious Bias & Cultural Awareness Training:** The Trust will target the training at frequent interview panel chairs and members Consider adopting the NHS Employers tools for Value Based Recruitment	**November 2021 - Ongoing** • ED&I Lead • Education Team • Recruitment Team
Action 6: Adopt resources, guides and tools to help leaders and individuals have productive conversations about race	To enable tangible progress on equality, diversity and inclusion for all staff and increase staff retention and likelihood of promoting candidates from diverse backgrounds	**Board Development Programme** Deliver the agreed board development programme to inform Trust's Inclusion Mission and revised strategic objectives **Resource & Guides** Develop 'How to establish a staff network' guide to help staff to set up a network at the Trust Signpost staff to various social media sites and publications from organisations i.e. CIPD 'How to talk about gender equality at work'	**June 2021 – March 2022** • OD Team • ED&I Lead **July 2021 – March 2022** • ED&I Lead **August 2021 – March 2022** • Communications Team • HR Team

		Supply a glossary of terminology	**August 2021 – March 2022** • ED&I Lead

Alert, Advise, Assure (AAAs)
Highlight Report

Committee/Group:	Finance, Performance & Investment Committee
Meeting date:	25 October 2021
Lead:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The financial gap for H2 is £5.5m, excluding the issues with the income allocation from the Health and Care Partnership.
- Due to the cash support required in Q4, authorisation to access DHSC support will be required in advance.
- Fluctuating Wave 3 Covid19 position with % of beds occupied by Covid-19 patients ranging between 5% and 10%. H2 plans levels of 7% (NEL 1+ day LOS) for winter.
- Staffing shortages due to Covid-19 and Non-Covid impacting service delivery. Key challenges in ED, maternity and escalation wards.
- Endoscopy capacity is limited by the Trust's ability to only deliver single sex lists which is impacting upon waiting times for cancer.
- Cancer performance across 14 day, 62 day and 104 day metrics has deteriorated month on month. Tumour specific action plans developed with weekly Cancer Improvement Group established and chaired by COO with ADO's in attendance.

ADVISE

- The Trust has submitted a bid for £5.8m as part of the Unified Technology Fund.
- The two schemes that have been supported regionally to be put forward to the national team as part of the Targeted Investment Fund (TIF) are the c-arm and discharge lounge totalling £1.1m.
- The three fire surveys for the Ormskirk site are due to be completed mid-November.
- The capital programme will be revised to account for the boiler replacement at the Ormskirk site now being planned to take place in 2022/23 rather than 2021/22.
- The Committee were 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. There were 49 x 12 hour breaches reported in September 2021.
- Theatre utilisation at both sites improved in September. 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.

ASSURE

- The Trust achieved breakeven for H1.
- The fire compartmentation and alarm work at the Southport site is progressing.
- The remediation work to the network and Wi-Fi is progressing.
- The Estates team are currently finalising the timelines for the work on the admissions area in endoscopy at the Ormskirk site.
- 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.

New Risks identified at the meeting:
None

Review of the Risk Register: *No action taken*

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO028/21**	**FOI Exempt**	**No**
Report Title	**STATEMENT OF COMPLIANCE 2021/22 CORE STANDARDS SELF-ASSESSMENT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)**		
Executive Lead	Lesley Neary, Chief Operating Officer		
Lead Officer	Greg O'Neill/Chris Pilkington, EPRR Team		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To assure the Strategic and Operational Committee that a self-assessment has been completed.

Executive Summary

NHS England and NHS Improvement has a statutory requirement to formally assure both itself and the NHS in England of EPRR readiness. This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is agreed by the organisation's board/governing body.

Following self-assessment, and in line with the definitions of compliance, the organisation declares itself as demonstrating **Fully Compliant** against the EPRR Core Standards.

Recommendations

The Strategy and Operations Committee is asked to take **assurance** that the Trust is prepared for an emergency and endorse the Statement of Compliance.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Chris Pilkington	Lesley Neary

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NHS Trust

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

CORE STANDARDS SELF-ASSESSMENT

Lesley Neary

Chief Operating Officer

3rd November 2021

Introduction

Southport and Ormskirk Hospital NHS Trust

- The EPRR Core Standards assessment has 3 elements
    - EPRR Core Standards
    - Interoperable Capabilities
    - Deep Dive – Oxygen Supply

Number of Applicable Standards

Southport and Ormskirk Hospital NHS Trust

- Acute providers: 46
- Specialist providers: 38
- Community providers: 37
- Mental Health providers: 37
- CCGs: 29

Some of the above standards require organisations to ask for assurance from other organisations and consideration needs to be given to commissioning relationships and co-located sites.

NHSEI Compliance Process

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Southport and Ormskirk Hospital
NHS Trust

Compliance Level	Evaluation and Testing Conclusion
FULL	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
SUBSTANTIAL	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
PARTIAL	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
NON-COMPLIANT	The organisation is compliant with 76% or less of the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Statement of Compliance

Southport and Ormskirk Hospital NHS Trust

- Southport and Ormskirk Hospital NHS Trust (SOHT) has undertaken a self-assessment with senior colleagues, against required areas of the EPRR Core Standards Self-Assessment tool v1.0.

- The Self-Assessment was submitted to NHSE in October 2021 and a check & challenge session was undertaken by NHSE.

- Following review of the self-assessment, NHSE has assigned SOHT an EPRR Assurance Rating of FULL compliance against the EPRR Core Standards.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO028/21**	**FOI Exempt**	**NO**
Report Title	**WINTER PLAN**		
Executive Lead	Lesley Neary, Chief Operating Officer		
Lead Officer	Lesley Neary, Chief Operating Officer		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

Following on from previous discussions the committee are asked to approve the proposed winter plan and critical schemes for progression.

Executive Summary

- This paper provides an update on the Trust's plans for winter 2021/22 in terms of meeting expected increase in demand levels.
- Critical schemes have been prioritised with a total expected cost of c£1.14m.

Priority	Indicative Costs (£000)	Comments
CRITICAL	1,139	Includes £209k in run rate
HIGH	720	Additional expenditure
MEDIUM	554	Includes £70k in run rate Plus additional £1m Discharge Lounge external capital bid
TOTAL	2,413	Includes £279 in run rate Plus £1m Discharge Lounge capital bid

Recommendations

The committee are asked to

- Note the additions to the number of critical schemes
- Note the amendments to timescales for each of the critical schemes
- Note the amendments to the finances for each of the critical schemes
- Approve to progress with the critical schemes

Previously Considered By:

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

Strategic Objectives

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

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

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

Southport and Ormskirk Hospital
NHS Trust

Internal Winter Plan

November 2021

Lesley Neary – Chief Operating Officer

3 November 2021

Southport and Ormskirk Hospital
NHS Trust

Introduction

- Executive Management Team (ETM) received and approved DRAFT winter plan September 2021
- Draft winter plan presented at FP&I committee in September 2021
- Draft winter plan presented at S&O Committee for information October 21
- Agreed to focus on critical schemes and what any other schemes required
- For the critical schemes reviewed the costs and timescales for implementation
- System winter plan check and challenge taken place last week
- Signed off by ETM 26th October 2021
- H2 planning submission £1.2m for winter signed off at FP&I in October 2021.

Southport and Ormskirk Hospital
NHS Trust

Summary Key Winter Schemes 2021/22

Priority	Indicative Costs (£000)	Comments
CRITICAL	**1,139**	Includes £209k in run rate
HIGH	**720**	Additional expenditure
MEDIUM	**554**	Includes £70k in run rate Plus additional £1m Discharge Lounge external capital bid
TOTAL	**2,413**	Includes £279 in run rate Plus £1m Discharge Lounge capital bid

The committee are asked to

- Note the additions to the number of critical schemes
- Note the amendments to timescales for each of the critical schemes
- Note the amendments to the finances for each of the critical schemes
- Approve to progress with the critical schemes

Southport and Ormskirk Hospital
NHS Trust

Key Schemes for Winter 2021/22 (CRITICAL)

Scheme	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Winter Ward (11a)	**CRITICAL**	• Open 20 beds on ward 11a for medicine with safe staffing levels to support escalation between Nov 21 & Apr 22	**Nov 21**	**Feb 22** *(Apr 22)*	**487** *(731)*	• 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**	• Paediatric ED Operating 24/7 at ODGH	**Nov 21** *(Oct 21)*	**Feb 22** *(Mar 22)*	**297** *(446)*	• 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**	• Working alongside the Head of Patient Flow, employ a Band 8a matron focused on supporting timely safe discharge.	**Nov 21** *(Sep 21)*	**Mar 22**	**24** *(34)*	• 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**	• Provision of additional patient transport weekend & evenings to support flow in addition to existing NWAS PTS	**N/A**	**Mar 22**	**175**	• 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**	• 12 days of Christmas campaign • Well being January campaign • Feel good February campaign	**Nov 21**	**Feb 22**	**45**	• Improve staff morale • Reduce staff sickness absence

Southport and Ormskirk Hospital
NHS Trust

Key Schemes for Winter 2021/22 (CRITICAL)

Scheme	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
NEW **Enhanced surgical cover overnight**	**CRITICAL**	• Extend registrar cover on site from 9pm until midnight.	**Nov 21** *(Oct 21)*	**Feb 22** *(Mar 22)*	**23** *(35)*	• 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.
NEW **Enhance surgical cover at weekends**	**CRITICAL**	• Additional FY2 to support surgery and T&O at weekends	**Nov 21** *(Oct 21)*	**Feb 22** *(Mar 22)*	**21** *(31)*	• 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
NEW **Enhanced therapy at ward level**	**CRITICAL**	• Additional Physio and OT on acute and winter wards	**Nov 21** *(Oct 21)*	**Feb 22** *(Mar 22)*	**67** *(100)*	• Supports flow due to heightened admission profiles • Ensures discharges are not delayed to incomplete TADs • Supports reduction in LOS

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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**	• 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**	• Reduce 4/12 hour breaches • Reduce 12 hour DTA breaches • Improve patient experience & outcomes
Enhance Surgical Flow coordinator	**HIGH**	• Additional 1WTE band 5 Surgical Flow coordinator to support surgical flow	**Oct 21**	**Mar 22**	**17**	• 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
Enhanced Medical Cover Evening & Overnight	**HIGH**	• Additional senior doctor in medicine overnight	**Oct 21**	**Mar 22**	**160**	• Provides additional senior (ST/SAS) medical cover evening and overnight to respond to increased acuity/ admissions • Provides supervision for F1 doctor on wards overnight Reduces delay in review overnight • Reduces risk of harm due to delayed medical review
Increased Mental Health Support in ED	**HIGH**	• Response and review within 1 hour • Escalation and pathway review & operational • No delays in assessment for T4 beds for all CAMHS patients	**Dec 21**	**Feb 22**	**100**	• Reduce 4/12 hour breaches • Reduce 12 hour DTA breaches • Improve patient experience & outcomes

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Key Schemes for Winter 2021/22 (MEDIUM)

	Priority	Scheme Description	Start Date	End Date	Cost (£000)	Expected Outcomes
Transfer Team Twilights	**MEDIUM**	• Nursing and HCA team to support transfer from ED to AMU and AMU to ward	**Oct 21**	**Mar 21**	70	• 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**	• Relocate Discharge Lounge to new Portacabin near main Entrance	**TBC**	**TBC**	£1m Capital Bid submitted	• 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**	• 4 Bedded Frailty Assessment Unit in SALUS Centre • Codependency with discharge lounge above	**Oct 21**	**Mar 22**	Nil – within existing	• 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**	• Operate Ambulatory Medical Care Unit extended hours	**Dec 21**	**Mar 22**	448	• 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**	• 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	• 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

Southport and Ormskirk Hospital
NHS Trust

Key Risks to Delivery

- Workforce
- Increase in Covid
- Increase in NEL demand
- System response

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

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COMMITTEE/GROUP:	Quality & Safety Committee (QSC)
MEETING DATE:	25 October 2021
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Alert from September:

- **Annual Report: Resuscitation** – the service requires further resources to ensure all Quality Standards (UK Resuscitation Council) are met.
  UPDATE: Resuscitation team supported to undertake gap analysis and submit business case for additional resource needed.

Alert for October:

- **Cancer Services Annual Report** – challenge relating to diagnostic resource and impact on cancer performance identified. Being managed through PIDA with tumour specific action plans.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

- **Infection Prevention Control (IPC BAF)** – Increasing incidence of C. diff rates. Action plan presented.
- **Lost to Follow Up and Clinical Harm Review** – Harm reviews underway. Focus required to reduce time taken to close incident. Reporting through CEC.
- **Corporate Risk Register** – Requires further review next month.
- **Patient Safety Monthly Update** – Noted
- **Quality Priorities Improvement Plan** – Noted
- **Core Mandatory Essential Skills Training Compliance** – Continued focus on improving compliance.
- **Patient Experience and Community Engagement** – Progress noted.

ASSURE

(Detail here any areas of assurance that the committee has received)

- **Orthopaedic Review** – Progress being made against all actions.
- **Integrated Performance Report** – Metrics reviewed.
- **Board Assurance Framework** – Risk reviewed.
- **Learning from Deaths** – Presented learning from holistic perspective.

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)

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO030/21**	**FOI Exempt**	**YES / NO**
Report Title	**LEARNING FROM DEATHS QUARTERLY REPORT**		
Executive Lead	Dr Kate Clark, Medical Director		
Lead Officer	Dr Chris Goddard, Associate Medical Director for Patient Safety		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

The purpose of this report is to provide an update to the Committee on learning from deaths activity for Quarter 2 2021-22.

Executive Summary

The report presents the Committee with an update of Trust performance against both national and local mortality indicators and mortality performance; analysis of avoidable deaths; analysis of a number of themes identified on end of life care, clinical and patient property for Quarter 2 2021-22.

Recommendations

The Committee are recommended to receive the themes raised in the Learning from Deaths update for Quarter 2 2021-22.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Dr Chris Goddard	Dr Kate Clark

Southport and Ormskirk Hospital
NHS Trust

Learning From Deaths

Quarter 2 2021

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

NHS

Southport and Ormskirk Hospital

NHS Trust

Key national and local mortality indicators

	2020/21							2021/22					Target
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Rolling 12 Month HSMR	80.8	80.7	79.5	79.2	79.5	79.4	76.9	73.7	73.2				*100.0*
Monthly HSMR	60.0	93.5	74.5	78.1	89.4	70.1	66.2	74.3	71.4				*100.0*
SHMI	105.4	106.1	106.6	105.2	103.2	103.4	100.9	98.6					*100.0*
Local HSMR Bronchitis	90.3	85.9	84.4	87.3	80.3	49.9	31.8	10.1	10.2				*100.0*
Local HSMR LRTI	96.1	86.5	84.9	87.6	80.5	49.9	31.9	30.0	27.1				*100.0*
Local HSMR Pneumonia	82.1	81.5	81.2	86.2	89.4	90.1	82.8	81.0	79.7				*100.0*
Local HSMR Septicemia	78.0	77.2	78.3	75.1	77.2	75.5	74.2	76.6	77.5				*100.0*
Local HSMR Stroke	98.4	102.0	93.8	94.5	89.5	91.9	93.4	90.9	89.3				*100.0*
Local HSMR UTI	78.3	94.7	99.1	102.6	96.0	104.1	95.9	85.7	85.2				*100.0*
Local HSMR FNOF	67.9	65.4	71.2	74.4	69.8	55.8	49.4	36.4	39.0				*100.0*
Mortality Screens - %	21.43%	12.79%	14.13%	11.63%	10.00%	13.25%	15.00%	15.25%	14.08%	14.00%	6.76%	0.00%	*90.00%*
SJRs	2.0	1.0											*0.0*
2nd Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	*0.0*
In Hospital Deaths	56.0	85.0	94.0	87.0	110.0	83.0	60.0	58.0	72.0	50.0	75.0	77.0	*77.0*
In Hospital Deaths Crude Rate	29.2	39.5	31.7	36.4	56.2	25.6	19.5	21.2	23.2	18.0	26.2	21.2	*31.0*
LD Deaths	0.0	2.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	1.0	*1.0*
Sickness Absence Medics	2.45%	2.40%	3.46%	3.28%	3.29%	3.35%	2.75%	2.37%	1.74%	1.22%	1.34%	1.62%	*1.00%*

Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

Southport and Ormskirk Hospital
NHS Trust

Avoidable deaths Quarter 2 2021

No avoidable deaths have been recorded by the incident management system or mortality review system this quarter.

There are complex cases informing this report and a simplistic judgement on avoidability in some of theses cases is simply not possible.

NHS
Southport and Ormskirk Hospital
NHS Trust

Quarter 2 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- End of life Care

  - Not having the chance to be present at death was a major concern for bereaved families. This is often due to an unwillingness to recognise that patients are likely to be dying or are sick enough to die, by doctors, or not conveying to relatives in a way that they can understand that their loved on is 'sick enough to die'.

  - When an individual plan for the care of those thought likely to be dying is developed with the patient and those important to them, this seems to support and promote the measures necessary to give good quality end of life care and should be used.

  - When relatives aren't aware of the prognosis from slowly progressive conditions such as heart failure or COPD they find death a shock. This can be prevented by better communication and explanation of the likely progression of the disease. This can also be the start of an Anticipatory Clinical Management Plan.

  - Relatives are overwhelmingly positive about the quality of care delivered. Kindness and treating people as individuals are the most common compliments. Poor communication is the biggest theme for complaint.

Southport and Ormskirk Hospital
NHS Trust

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Property issues are a common theme; losing things with emotional value or mistakes with property are common complaints.

- Sudden Cardiac death in younger individuals without an obvious precipitant should be considered for referral to the coroner. The Medical Examiner will consider and advise, but 2 cases in the past month have been accepted by HM Coroner for a specialist cardiac post-mortem – this can have genetic implications for family members.

- The above point is important in patients going for organ donation. Donation can proceed, but arrangements for limited post-mortem need to be arranged through HM coroner.

- The lack of ability to accommodate routine visiting for inpatients compounds the issues of poor communication, and removes key opportunities for staff to discuss diagnosis and prognosis with patients and families together.

Southport and Ormskirk Hospital
NHS Trust

Quarter 2 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Property issues are a common theme; losing things with emotional value or mistakes with property are common complaints.

- Clinical Care

  - The development of acute confusion, which is often initially minor, is a significant clinical risk for patients. This is a recurrent theme in falls over bed rails, some of which have directly resulted in death. Acute confusion has also consistently been an early sign of clinical deterioration - frequently due to sepsis.

  - There was evidence that excellent care is achieved by good clinical communication between teams. Different specialties working collaboratively and supportively gave the best quality of care.

  - The involvement of senior decision makers leads to the best quality of care, especially in complex cases.

  - Early, prompt diagnostics, especially diagnostic imaging, is associated with better diagnosis and better management.

Southport and Ormskirk Hospital
NHS Trust

Quarter 2 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Processes of care

  - Methods to promote standardisation in the treatment of high risk conditions or for the performance of high risk procedures produced safe, quality medical care. Pathways and LoCCsips, when used, are associated with good medical care.

  - Documentation. Good documentation reflects the interpretation of the quality of care delivered. Time taken on this is time well spent. Poor documentation cannot be defended and only impairs future patient care – as what is written before informs this.

  - Managing work flows through written mechanisms such as ‘Job books’ is unreliable and prone to error. There is no audit trail and little if any governance. Their use has been one factor in a serious incident and a more reliable method of governing task allocation is needed.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGIC & OPERATIONS (S&O) COMMITTEE**	**Date**	**03 November 2021**
Agenda Item	**SO031/21**	**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	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **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

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.

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.

In this month's review of the IPC BAF actions there are no further categories that have been upgraded from green to blue with three actions remaining green; these include: action 1 regarding assessing and verifying appropriate ventilation in clinical areas – the assessment has by and large been completed however the report and recommendations are now pending, also included is providing assurance of IPC training – this has been accomplished for level 1 training, however level 2 is still just missing the 85% target and in September was reported as 81.43%. The final green action which has remained static 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.

Progress

IPC audits and mandatory training continues to be monitored:

1. Hand Hygiene Audits - Trust compliance September 2021 **(96.5%)** ↑ above target
2. PPE Compliance Audits - Trust compliance September 2021 **(95.9%)** ↓ above target
3. IPC Mandatory Training - Compliance –
    a. Level 1 September 2021 **(94.3%)** ↑ above target
    b. Level 2 training August 2021 **(81.43%)** ↓ 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 NWRSIC, however this wasn't expanded as the triggers then increased requiring only limited visiting in special circumstances. Comms has gone out to local media regarding visiting restrictions.

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.
- Recommendations from UK Health Security Agency (formerly PHE) received regarding acceptable variations to physical distancing, pre-procedure testing and standard cleaning procedures – no changes advised at this time as cases continue to increase and additional National IPC guidance due in October.

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:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
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Prepared By:	**Presented By:**
Andrew Chalmers	Bridget Lees

Publications approval reference: 001559

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 (September 21)	New BRAG Rating (October 21)
• **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:** ○ **a review of the effectiveness of the ventilation in the area.** ○ **operational capacity.** ○ **prevalence of infection/variants of concern in the local area.**	• 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 • On Friday 13/8/21 IPC presented to Trust Brief Live and included guidance	• Comms provided regarding social distancing and adequate ventilation. Clinical areas throughout the Trust have been assessed by authorized ventilation engineer to monitor air flow – this piece of work needs formal report completing with recommendations on actions required. This report is now pending and will be reported to the Bronze IPC meeting and through to Silver and Gold command structures.	• 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		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (September 21)	New BRAG Rating (October 21)
	on appropriate ventilation, room capacity and social distancing				
• **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;** No outstanding actions – all complete					
• **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;**	• 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			
• **resources are in place to enable compliance and monitoring of IPC practice including:** ○ **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 and are wearing appropriate PPE:**	• 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 ward – this is a new audit that has just been introduced; early results confirm	• None			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (September 21)	New BRAG Rating (October 21)
	that 100% of mobile in-patients wear a mask • Visiting is currently restricted. Any visitors that meet the visiting criteria 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 • Additional recommendations from UK Health Security Agency (formerly PHE) received regarding acceptable variations to physical distancing, pre-procedure testing and standard cleaning procedures – no changes advised at this time as cases continue to increase and additional National IPC guidance due in October				
• **training in IPC standard infection control and transmission-based precautions are provided to all staff**	• IPC Mandatory Training - Compliance – Level 1 September 2021(**94.3%)** – Target achieved. • Level 2 training September 2021 **(81.43%)** – just below target; and a small decrease on previous month (**82.48%)** • IPC training is covered in Clinical Induction which has remained mandatory for all new starters during Covid • Online YouTube training	Not reached 85% target for Level 2 IPC training in September 2021	Monthly training compliance report is circulated to CBUs monthly and managers/supervisors reminding staff of mandatory training Frequent reminders re IPC best practice circulated in Trust News. Information re IPC provided to staff at safety huddles Ward Walking by Quality Matrons, IPC Team and senior leaders; including adhoc training on the wards		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (September 21)	New BRAG Rating (October 21)
	• Week starting 18/10/21 National IPC week; quizzes and competitions promoting IPC scheduled • Throughout September and October Trust Comms to all employees re PPE and COVID precautions, including daily visits to inpatient areas by IPC team		by the IPC team – recent ward-based training included MRSA, C diff and hand hygiene.		

2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
	No outstanding Actions – all complete

3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
	No outstanding Actions – all complete

4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
	No outstanding items all complete

5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
	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 (September 21)**	**New BRAG Rating (October 21)**
• **consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance**	• There is a general principle that staff are not moved between wards unless there is an urgent need (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