Southport and Ormskirk Hospital NHS Trust

AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE (Part 1)

To be held at 0930 on Wednesday 06 July 2022

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO119/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO120/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO121/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO122/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 01 June 2022.*	No	*Chair*	10 mins
SO123/22 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
STRATEGIC AND GOVERNANCE				**0955**
SO124/22 (D)	**Audit Committee AAA Highlight Report** *Purpose: To **receive** the Audit Committee AAA Highlight Report*	*No*	*I Clayton*	5 mins
SO125/22 (D)	**Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	*No*	*N Bunce*	10 mins
SO126/22 (D)	**Corporate Risk Register** *Purpose: To **receive** the Corporate Risk Register*	*No*	*K Clark*	10 mins

INTEGRATED PERFORMANCE REPORT				**1020**
SO127/22 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations c) Finance d) Workforce *Purpose: To **receive and note** the IPR for assurance.*	*No*	*L Barnes* *K Clark* *L Neary* *J McLuckie* *J Royds*	20 mins
QUALITY & SAFETY				**1050**
SO128/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report*	*No*	*G Brown*	10 Mins
SO129/22 (D)	**Learning from Deaths Report Quarter 4** *Purpose: To **receive** the Learning from Deaths Report Quarter 4 for assurance*	*No*	*K Clark*	10 mins
SO130/22 (D)	**CQC Action Plan Progress Report** *Purpose: To **approve** the CQC Action Plan Progress Report*	*No*	*L Barnes*	10 mins
SO131/22 (D)	**Annual Reports endorsed by Quality and Safety Committee** a) Infection Prevention and Control Annual Report b) Safeguarding Annual Report c) Annual Integrated Governance Safety Report *Purpose: To **receive** and **note** the Annual Reports*	*No*	*K Clark* *L Barnes*	
WORKFORCE				**1120**
SO132/22 (D)	**Workforce Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Workforce reports*	*No*	*L Knight*	10 mins
FINANCE, OPERATIONS AND INVESTMENT				**1130**
SO133/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer*	10 mins
CORPORATE				**1140**

SO134/22 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report*	*No*	*AM Stretch*	10 Mins

CONCLUDING BUSINESS				**1150**
SO135/22 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*5 mins*
SO136/22 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	*5 mins*
	Date and time of next meeting: 0930 Wednesday 07 September 2022			***1200 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

Minutes of the Strategy and Operations Committee (Part 1)
Held on Microsoft Teams
Wednesday 01 June 2022
(Approved by the Strategy and Operations Committee on 06 July 2022)

Present

Name	Initials	Title
Richard Fraser	RF	Chair, STHK
Ann Marr	AM	Chief Executive
Anne-Marie Stretch	AMS	Managing Director
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Gill Brown	GB	Non-Executive Director, STHK & S&O
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director, STHK & S&O
Lisa Knight	LK	Associate Non-Executive Director, STHK
Jeff Kozer	JK	Non-Executive Director, STHK
John McLuckie	JMcL	Director of Finance
Lesley Neary	LN	Chief Operating Officer
Rowan-Pritchard-Jones	RPJ	Medical Director, STHK
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, STHK
Jane Royds	JR	Director of HR and OD
Rani Thind	RT	Associate Non-Executive Director, STHK
Christine Walters	CW	Director of Informatics, STHK

In Attendance

Name	Initials	Title
Geoffrey Appleton	GA	Board Advisor, STHK
Tony Ellis	TE	Communications and Marketing Manager *(Item SO095/22 only)*
Alan Sharples	AS	Board Advisor, STHK
Juanita Wallace	JW	Assistant to ADCG (minute taker)

Apologies

Name	Initials	Title
Kate Clark	KC	Medical Director
Rob Cooper	RC	Director of Operations and Performance, STHK
Paul Growney	PG	Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, STHK
Stephen Mellars	SM	Deputy Director of Nursing
Nina Russell	NR	Director of Transformation

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO095/22	**Patient Story**	
	LB introduced the patient story video which focused on Animal Therapy in a hospital setting and the impact on staff and patient experience. Judith and Jack (her dog) are members of Therapy Dogs Nationwide and had supported patients within the Trust pre-Covid-19 and supported staff	

	with therapy visits, where safe to do so, during the previous year. Patients loved meeting Jack and the other therapy pets and they provided a wonderful distraction. When the Government changed the policy on animals within a hospital setting in 2019, the Intensive Therapy Unit (ITU) had contacted Therapy Dogs Nationwide and Judith had responded. Judith has been a member of Therapy Dogs Nationwide since 2018 and Jack has been a therapy dog from five months old. It was noted that all animal visits were in line with the Infection, Prevention and Control (IPC) procedures and that Animal Therapy at Southport and Ormskirk NHS Trust (S&O) included therapy dogs and pony visits. The Trust was celebrating the start of Volunteers Week on 01 June and LB advised that there were over 80 volunteers that worked across both sites in a variety of settings to assist patients. The Trust had also recruited its first neonatal volunteer to support the breastfeeding initiative. Additional administrative support for the Volunteer Recruitment Manager had been provided to support growth of the Volunteer programme. LB advised that the Volunteer Policy had been reviewed and the age limit for volunteers had been reduced to 16 years of age which provided a fantastic opportunity to give young people an insight into healthcare professions and hopefully aid future recruitment. RF reflected on the value of volunteers to enhance the NHS experience. Additionally, he asked if the Trust was part of the Duke of Edinburgh scheme for young volunteers and LB agreed to look into this. GB reflected on the important role of the volunteers and was impressed by the range of pet therapy within the Trust. GB asked if the Hospital Charitable Funds were used to support the work of volunteers and LB confirmed that the Charitable Funds Committee was always willing to respond to requests, where it could. **RESOLVED** The Strategy and Operations Committee **received** the Patient Story	
SO096/22	**Chair's Welcome and Note of Apologies**	
	RF welcomed all to the meeting. Apologies for absence were **noted** as detailed above.	
SO097/22	**Declaration of interests**	
	There were no declarations of interests in relation to the agenda items.	

SO098/22	**Minutes of the previous meetings**	
	The Committee reviewed the minutes of the previous meeting held on 04 May 2022 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Strategy and Operations Committee **approved** the minutes from the meeting held 04 May 2022	
SO099/22	**Matters Arising and Action Logs**	
	The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. **RESOLVED:** The Strategy and Operations Committee **approved** the action log	
STRATEGIC AND GOVERNANCE		
SO100/22	**NHS Data Security and Protection Toolkit Update**	
	JMcL presented the report which provided an update regarding the Trust's progress in submitting the assurance against the National Guardians 10 data security standards that are mandated for NHS Trusts. The Trust needed to submit 110 mandatory evidence items across 38 assertions to demonstrate it was compliant with the standards. Currently the Trust had submitted evidence against 106 of the items and had action plans in place to complete the remaining items before the deadline of 30 June to achieve a "standard met" assessment. Mersey Internal Audit Agency (MIAA) would be auditing the submissions. JMcL advised that a Penetration (PEN) test, which was a simulated cyber-attack against the Trust's computer system to check for exploitable vulnerabilities, was due to be completed between 06 to 13 June 2022. ICL questioned the backup plans that MIAA had highlighted during a recent audit and JMcL advised that these were now in place, but evidence of the testing needed to be provided and that, as part of the Business Continuity Planning (BCP), LN would be arranging a systems test which would be referenced. It was noted that 92.5% of staff had completed their annual Information Governance Data Security Awareness Training against a target of 95% and the Trust was currently not compliant in this area. JMcL advised that	

	this equated to 300 staff members who needed to complete their training and that this was achievable by the end of June 2022. **RESOLVED:** The Strategy and Operations Committee **noted** the NHS Data Security and Protection Toolkit Update	
SO101/22	**Effectiveness Review - Annual Workplans**	
	NB presented the annual work plans for the Strategy and Operations Committee (SOC) and the Assurance Committees that had been reviewed and updated as part of the annual effectiveness review and advised that the Terms of Reference for the assurance committees as well as the SOC work plan had been approved at SOC in April 2022. The annual work plans for the assurance committees had now been aligned to the Terms of Reference and coordinated with the SOC work plan. GB noted that some items appeared to be missing from the Quality and Safety Committee (QSC) work plan, however it was established that the document was incomplete and would be recirculated. However the full document had been reviewed and agreed at the last QSC meeting. IC suggested the updates on the Care Quality Commission (CQC) inspection action plan should be reported to SOC rather than just the QSC until all the actions had been formally closed. IC also suggested that the Finance, Performance, and Investment Committee work plan should be amended to receive the Cost Improvement Plan (CIP) updates from the worst performing areas first rather than on a random basis. NB advised that this item had not been listed in an order and that JMcL and LN would agree which Clinical Business Unit should present the CIP update as performance would change over time. **RESOLVED:** The Strategy and Operations Committee **approved** the Annual Work plans for the Strategy and Operations Committee and the Assurance Committees for 2022/23.	
INTEGRATED PERFORMANCE REPORT		
SO102/22	The Committee received the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local performance metrics during April 2022.	

	a) Quality and Safety Performance Report	
	LB presented the report which provided an overview of performance against the quality and safety metrics. It was noted that: • There had been amendments to some of the metrics or targets to reflect the new 2022/23 Quality Priorities and local and national benchmarking data had been added and the Statistical Process Charts (SPC) had been updated to reflect this. • One Never Event had been recorded and a root cause analysis (RCA) was being completed and lessons learnt were being shared Trust wide. It was noted that there had been no harm caused to the patient. • Five cases of hospital-acquired Clostridium difficile (C.diff) had been reported and, following the completion of the RCAs, no lapses in care had been highlighted. • Two falls with moderate harm had been reported during April which was above target. • There had been a slight decline in patient experience Friends and Family Test recommendation ratings, in certain areas, e.g. maternity services and additional support was being provided. The re-introduction of visiting should lead to an improvement in patient and family experience. AS asked whether the never event had been reported and LB advised that, whilst the issue had been recognised before the end of the procedure, it had still been reported via STEIS and had also been reported to the CQC and the Critical Care Network for learning across the system. **RESOLVED** The Strategy and Operations Committee **received** the Quality and Safety Performance Report	
	b) Operational Performance Report	
	LN presented the report which provided a summary of operational activity and constitutional standards and advised that whilst there had been a reduction in Covid-19 numbers in May, during April 9.5% of available beds had been occupied by Covid-19 patients against the planning assumption of 1.5%. There had been an improvement in the Sickness absence rate from 7.8% in April (Covid-19 2.1% and non-Covid 5.7%) to 6.7% in May (Covid-19 1%, Non-Covid 5.7%.) LN highlighted the following: • The Trust remained challenged against the Emergency Department 4hour performance standard. This continued to compare well to other Trusts in Cheshire and Merseyside (C&M), the Northwest and nationally.	

- There had been a reduction in the number of 12hour breaches in April
- Elective recovery and restoration had been impacted by the challenges in Urgent and Emergency Care and total admitted activity was 100% of 2019/20 levels against a target of 104%. Measures had been put in place to improve this performance, but it would remain a risk whilst the urgent and elective pressures remained high.
- Endoscopy continued to show improvement at 119% against 2019/20 levels.
- Performance against the diagnostic targets had deteriorated in April because of reduced capacity for Magnetic Resonance Imaging (MRI) scans and workforce challenges in the Computerised Tomography (CT) team. This was further impacted by reduced capacity delivered by the Walton Centre.
- LN reported that the Trust was performing well against the targets to eliminate 52 and 78 week waiting list patients and that surveillance patients from the 2019/20 waiting list were now included on the active waiting list in line with the national mandate.
- The Cancer performance improvement plan at tumour site level had been presented to the Quality and Safety Committee (QSC).

GB commented that the criteria to reside metric was new and asked if this was more useful than the super stranded measure. LN advised that the national team was striving for consistency across all trusts when reporting the number of patients that were ready for discharge, however the new metric did not take into account whether the patient still met the criteria to remain in an acute trust.

JK reflected that he would like to obtain a better understanding of the stranded and super stranded metrics and the new arrangements as well as what the system was doing collectively, and LN agreed to arrange a meeting to discuss this with him.

RT commented on the head and neck cancer action plan and asked if the Trust was working with the Cancer Alliance and if progress was being made. LN advised that the Trust had a good relationship with the Cancer Alliance and that they were supportive and working with the Trust to deliver the improvement plans as the pathway for head and neck cancers were complex and multi-organisational. The Cancer Alliance had provided funding to recruit additional cancer trackers to assist with cancer patient management. It was noted that St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) faced similar challenges in relation to the head and neck pathway and that the service was delivered by Liverpool University Hospitals NHS Foundation Trust (LUHFT) and AM advised that she was currently discussing the Service Level Agreements (SLA) regarding this service with LUHFT.

	AM commented that the Provider Collaborative had raised a concern regarding cancer performance across the region as a whole and discussions had been held with the Cancer Alliance regarding the need to start focusing on head and neck cancer as well as gynaecological cancers. LN advised that the Trust was seeking mutual aid from the Liverpool Women's Hospital NHS Foundation Trust and had submitted an expression of interest to the Integrated Care Board (ICB) in relation to gynaecological surgery. IC reflected on an Index of Cancer Survivors report that he had read and commented that Southport had been listed at the top for five-year breast cancer survival. LN agreed to discuss this with IC offline as the S&O Trust was not commissioned to provide breast cancer support. RPJ commented that the Southport and Formby Clinical Commissioning Group (CCG) had the most improved cancer survival rate in the country and that the outcomes for patients were among the most improved in the country. AM felt that one of the biggest challenges for elective recovery remained the patient flow and discharge delays and that it would be important to resolve the root cause of these issues which was social care capacity. GB asked if data showing the number of care home beds available for Southport and Ormskirk was shared with the Trust on a regular basis as she was aware that there were also a number of challenges facing care homes which included workforce challenges. AM advised that the Trust was aware of several care homes that were closed or partially closed due to staffing issues and reflected on a piece of work carried out in the Northeast where NHS staff were used to open care homes which were then run as an extension of the hospital premises and this might be a route to pursue more seriously. LN commented that care homes had experienced the same challenges as hospitals around Covid-19 sickness. An additional challenge is that Southport has an older population that required more support and that some nursing homes were not able to admit these patients due to staffing issues. Furthermore, there were beds available in the care homes, but these were not always the right type of beds for the specific needs of the patient. LN clarified that information on the social care bed availability was shared with the Trust. RF reflected that at the recent Northwest Chairs Meeting a request for Type 2 Ambulance Performance to be reported at acute Trust Board meetings had been made and he was intending to discuss this when he met the Northwest Ambulance Service NHS Trust (NWAS) Chair.	

	RF commented that the paper had highlighted the complex and difficult journey to recovery and thanked all involved for their hard work. **RESOLVED** The Strategy and Operations Committee **received** the Operational Performance Report	
	c) Financial Performance Report	
	JMcL presented the report which detailed performance against financial indicators and advised that the Trust had reported a £1.8m deficit in Month 1 in line with the draft 2022/23 Financial Plan. This assumed 100% achievement of Elective Restoration Funding (ERF) for Month 1 pending confirmation of the allocation criteria. RF commented that, at a recent Northwest Chairs' meeting trusts had been told to make a further submission of financial plans to try and close the financial gap and he was concerned that the financial challenge could be unrealistic. **RESOLVED** The Strategy and Operations Committee **received** the Financial Performance Report	
	d) Workforce Performance Report	
	JR presented the Workforce Performance report and advised that: • The compliance rate for Performance Development Reviews (PDRs) had deteriorated again in month to 74.1% and a piece of work was being undertaken to update the Electronic Staff Records (ESR) structures and to complete a data cleanse. • Core mandatory training compliance remained on target, however, a stretch target of 90% had been introduced for 2022/23 in line with the People Plan. • Following a review, it had been determined that the increase in Time to Hire was due to overseas recruitment. RF raised a concern around the overall vacancy rate of 10.2% as other industries were recording a very low vacancy rate. JR advised that the Health Care Assistance (HCA) vacancies were an area of focus. **RESOLVED**	

	The Strategy and Operations Committee **received** the Workforce Performance Report	
QUALITY AND SAFETY		
SO103/22	**Quality and Safety Report**	
	a) Quality and Safety Committee AAA Highlight Report	
	GB presented the AAA Highlight report and alerted the Committee to the following: • The Maternity Quarterly Report included an update on the Ockenden gap analysis self-assessment with compliance challenges relating to workforce. • There was an update on the investigation and actions taken following the recent serious incident in the Maternity Service. • The Histology capacity, which was delivered by STHK, would be addressed via the pathology contract meeting. It was noted that the shortage of histopathologists was a national issue and was impacting the Cancer performance recovery plans. GB advised that the learning following the Never Event (retained guidewire) had been presented at Trust Brief as well as in Trust-wide communications. This had also been reviewed at the Serious Incident Review Group (SIRG) and there were ongoing actions to identify any additional human factors training that might be needed. The Committee had been assured by the ongoing ward improvements highlighted in the S&O Clinical Assessment and Accreditation Scheme (SOCASS) Report. The Quality Account 2021/22 (draft) had been reviewed for comments and a number of changes suggested. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Quality and Safety Committee.	
SO104/22	**Draft Quality Account 2021/22**	
	LB presented the final draft of the Quality Account 2021/22 which had been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. Additionally, she advised that the report was being presented to the Clinical Commissioning Groups (CCGs) later in the month and their comments would be added after these meetings had taken place.	

	It was noted that S&O had worked closely with STHK Quality Governance colleagues which had ensured a consistent format for the document whilst retaining a S&O Hospital NHS Trust focus. The document had been reviewed by the Quality and Safety Committee and the feedback received had been incorporated into the current draft. GA and GB both commented that the document was engaging and had highlighted the great work taking place at the rust despite the operational pressures and continued impact of Covid-19 during 2021/22. LB thanked the Assistant Director of Quality for her hard work in putting together the report. **RESOLVED:** The Strategy and Operations Committee **approved** the draft Quality Account 2021/22	
SO105/22	**Maternity Report including Ockenden II Self-Assessment**	
	LB presented the report that provided updates on: • Ockenden Report/Actions • CNST • Quality & Safety • Workforce Following the introduction of the Cheshire & Mersey Local Maternity & Neonatal Network (LMNS) standardised self-assessment template, the S&O Maternity Services had undertaken a benchmarking exercise against the 92 actions contained in the Ockenden Report to create an action plan to achieve full implementation. A peer review had been completed in partnership with STHK. A regional Insight Visit was planned for 10 June 2022. This was an assurance visit by the regional maternity team and would include a multidisciplinary team (MDT) and Maternity Voices Partnership (MVP) involvement. The visit would also provide an opportunity to review any gaps against the immediate and essential actions as well as discussing the progress made to date. The Clinical Negligence Scheme for Trusts (CNST) had been relaunched in May 2022. In light of the Ockenden report, several of the safety actions had been reviewed and new requirements had been added. The evidence now had to be submitted by a revised deadline of 05 January 2023. Following the serious incident in Maternity in May 2022, a S&O Quality Review meeting had been held to identify learning and the immediate and	

	longer-term actions needed to prevent a recurrence. The meeting had been attended by the Cheshire & Mersey Regional Team and key representatives from the Trust. **RESOLVED:** The Strategy and Operations Committee **received** Maternity Report including Ockenden II Self-Assessment	
WORKFORCE		
SO106/22	**Workforce Report**	
	a) Workforce Committee AAA Highlight Report	
	LK presented the AAA Highlight report and advised that there were no issues to be escalated to the Strategy and Operations Committee as alerts. LK advised that • There had been a further reduction in Performance Development Review (PDR) rates and the Committee was advised of the new approach that would be adopted to improve this. • There remained a gap in the Health Care Assistant (HCA) vacancies and recruitment events and open days had been arranged. It was noted that there was a national pay issue related to HCAs as the NHS salary for these staff members was lower than competing companies. The Trust's aim was to advertise the HCA role as the start of a career pathway in healthcare. The Committee had been assured by the Listening Plan presentation and how this would link into the cultural changes already in progress had been discussed. The Policy for Recruitment and Management of Volunteers had been approved. The Staff Story had been presented by one of the Trust's recent International Nurse recruits and had highlighted the high level of support that the international nurses had received when joining the Trust. She had also noted a few areas where there was room for improvement, which included housing and skill mix. RF commented on the positive feedback received and reflected on the importance of support both in and out of hospital for the international recruits.	

	LK commented that the international nurses had shared that they had received more support than many of their counterparts who were employed by other trusts. It had been pleasing to hear that the issues around housing (access to rented accommodation) had been taken on board and hopefully resolved. LB commented that the international nurse programme was a success and had created a diverse workforce which embraced different cultures. JR commented that the senior Nursing team and Human Resources had worked in partnership to ensure that the programme was a success. Additionally, she reflected on the retention of the international nurses and advised that only one nurse had left the programme as her husband had obtained a job elsewhere. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Report from the Workforce Committee	
FINANCE, OPERATIONS AND INVESTMENT		
SO107/22	**Finance, Performance and Investment Committee Reports**	
	a) Finance, Performance and Investment Committee AAA Highlight Report	
	JK presented the AAA Highlight report and alerted SOC to the following: • Due to the overall national financial position for 2022/23, a further plan submission was required by 20 June. • There had been an improvement in Accident and Emergency (A&E) performance, but performance was still below the national standard. • There had been an improvement across all cancer metrics though this was still below the standard. The report also advised that: • Month 1 financial position had reflected a £1.8m deficit. • A peer review of the costing systems between S&O and STHK had concluded that there was a mapping issue with non-elective care at S&O and this would be rectified in the next submission. • Recommendations from the recent Emergency Care Intensive Support Team (ECIST) had been presented. • The Orthodontic service was in the process of safely transferring all patient groups to alternative providers. The Committee had been assured that: • Orders had been placed for the fire alarms and compartmentation to continue safety work at both sites.	

	• Cyber security had been transferred to STHK as of 01 May and the process was underway to transfer Information Governance as well. • An implementation date of 19 September 2022 had been agreed upon for the North Mersey Acute Stroke Pathway. • Improvements in Endoscopy had continued in April 2022 and 119% of plan had been achieved, 143% of 2019/20 levels. JMcL provided an update on the improvements to the network and advised that the new Virtual Private Network (VPN) would be rolled out starting on 13 June and that users would receive a popup message to update the software. The replacement of the core switches at both sites would take place and JMcL and LN needed to agree on a suitable date in June. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance and Investment Committee.	
CORPORATE GOVERNANCE		
SO108/22	**Executive Committee Report**	
	AMS presented the AAA highlight report that detailed the activity and reports considered by the ETM during April and advised that the alerts noted in the report had been addressed earlier in the meeting. AMS advised that there was an ongoing discussion around the decision to temporarily close the Paediatrics Emergency Department overnight since 2020 April and she expected that this would be discussed at next week's Quarterly Joint Performance meeting with NHSE/I. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Executive Committee	
CONCLUDING BUSINESS		
SO109/22	**Questions from Members of the Public**	
	It was noted that no questions had been received from members of the public.	
SO110/22	**Any Other Business**	
	RF commented on the fulsomeness of the reports received and thanked all for their continued efforts.	

	There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.20. The next meeting would be held on **Wednesday 06 July 2022 at 09.30**	

Strategy and Operations Committee Attendance 2022/23												
STHK Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	✓	✓	✓									
Ann Marr	✓	✓	✓									
Anne-Marie Stretch	✓	A	✓									
Geoffrey Appleton	✓	✓	✓									
Gill Brown	✓	A	✓									
Nicola Bunce	✓	✓	✓									
Ian Clayton	✓	✓	✓									
Rob Cooper	✓	✓	A									
Paul Growney	A	A	A									
Lisa Knight	✓	✓	✓									
Jeff Kozer	✓	✓	✓									
Gareth Lawrence	A	✓	A									
Rowan Pritchard Jones	A	✓	✓									
Sue Redfern	✓	✓	✓									
Alan Sharples	✓	✓	✓									
Rani Thind	✓	✓	✓									
Christine Walters	✓	✓	✓									
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes	✓	✓	✓									
Kate Clark	✓	✓	A									
John McLuckie	✓	✓	✓									
Lesley Neary	✓	✓	✓									
Jane Royds	✓	✓	✓									
Nina Russell	✓	✓	A									
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 30 June 2022

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
SO049/22	06/04/2022	**Board Assurance Framework**	BAF to be updated to reflect the abovementioned amendments as well as the inclusion of an additional risk around the condition of the estates and the backlog maintenance issues	N Bunce	01/06/2022	~~01/06/2022~~ July 2022	**April Update:** BAF to be updated **June Update:** The updated BAF will be presented at the meeting on 06 July. **June Update:** The BAF has been updated to reflect the amendments as requested. ACTION CLOSED	**Blue**
SO050/22	06/04/2022	**Corporate Risk Register**	CW requested that firm dates as well as additional information around the mitigations be included in the plan. Additionally she recommended that the Business Continuity Plan (BCP) be updated to provide assurance that, if the risk materialised, evidence would be robust that the Trust would continue to operate	J McLuckie	06/07/2022	Jul-22	**April Update:** Action plan to be updated to reflect firm dates as well as additional information around mitigations and the BCP to be updated to provide assurance. **June Update:**	**Green**

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	AUDIT COMMITTEE
MEETINGS HELD:	15 June 2022
LEAD:	Ian Clayton

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The External Audit Completion Report had highlighted that, a new significant risk relating to fraud recognition, had been identified for the Trust because of the NHS continuing to operate block contracts.
- In September 2021 one significant weakness had been reported to the Trust and as part of the work undertaken during 2021/22 the progress made against the recommendations was followed up and it had been determined that the weakness had remained during the year and the previous recommendation that the Trust did not have a viable plan to return to financial balance once the normal operating framework was reinstated, would remain in place.
- The External Auditors had advised that a Section 30 Letter would be issued as the Trust had not met the requirement to breakeven over a three-year period and there was a planned deficit for 2022/23.

ADVISE

- None

ASSURE

- The Committee had agreed that, with some minor amendments, the 2021/22 Annual Report and Annual Governance Statement would be recommended to Trust Board for approval.
- The Committee agreed to recommend the 2021/22 Annual Accounts and Financial Statements to Trust Board for approval. It was noted that, following technical adjustments the Trust had broken even in year and that all additional capital funding received had been utilised in the financial year.
- The Losses and Special Payments report had reflected a reduction in payments made for the loss of patient's personal property during the 01 October 2021 to 31 March 2022.
- The Aged Debt Analysis reported progress made on collecting debts over 90 days old and most of the outstanding balances for the CCGs had been cleared.
- The Tender and Quotation report, which provided the rationale behind each request, was presented for the period 12 April to 26 May 2022 and the Committee was assured that the reason for the waiver regarding the review of the Medical workforce in Medicine and A&E was appropriate given the time constraints.
- The Committee was assured that the Register of Tenders and Contracts had been reviewed. It was noted that the contract for the provision and maintenance of air mattresses had been paused as this was part of the total Bed Management review.

New Risks identified at the meeting	None
Review of the Risk Register? No	

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO125/22**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK – QUARTERLY REVIEW**		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To review the Board Assurance Framework (BAF) and approve the proposed changes.

Executive Summary

The BAF allows the Directors to understand how the controls put in place by the Trust to provide assurance on the reduction of risk in relation to the delivery of its strategic objectives. The BAF report is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls.

Since presentation at the last meeting, the BAF has been reviewed by the lead executive for each strategic risk and the individual risks have been presented to the relevant assurance committees and the Audit Committee. In response to the last review in April 2022, an additional strategic risk has been added to the BAF in relation to the essential estate's infrastructure of the Trust.

This risk will impact on the delivery of strategic objective 2 and has been added as SO2c

Key to changes:

~~Scored through text~~ = deletions
Blue text = additions/updates
Red Text = overdue actions

It is proposed that the score of risk SO4 be increased to 16 to reflect the workforce pressures being faced by the Trust and the impact this has on the provision of safe and sustainable services.

It is proposed that the score of risk SO2c be updated to 20 to reflect the level of risk that remains and recognising that the work (mitigation) programme is ongoing.

Recommendations

The Strategy and Operations Committee is asked to note the updates and approve the proposed changes to the BAF.

Previously Considered By:

☐ **Strategy and Operations Committee**	✓ **Executive Committee**
✓ **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:**
Nicola Bunce, Director of Corporate Services	Nicola Bunce, Director of Corporate Services

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 June 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	5	15	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. Trust Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing five priority areas: • Falls • Pressure Ulcers • AKI: hydration & nutrition • Communication with families • Ockenden Compliance 4. Risk Management Strategy and escalation framework. 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 actions from 2019 inspection complete. Continued oversight through Quality priorities 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. Patient safety specialist roles 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. 10. Medical Examiners office/officers now set up and in practice. **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. SOCASS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian 10. IPC BAF 11. Winter Staffing Assurance Framework Assessment **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits	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.	~~1.~~ Clinical workforce strategy to be completed – ~~by end of Jan 21.~~ **June 22 Update: Draft completed. To be presented for approval at Workforce Committee in July 22?** **Outstanding CQC actions included in agreed quality priorities. Monitoried through SOCAAS and Reporting to QSC & SOC (monthly)** 2. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. **June 22 Update: MIAA audit Management Actions progressing as per plan** 3. Complete review of Risk Management Policies and Assistant Director of Integrated Governance now developing a framework with associated training to bridge the gap on Risk Management Training in the Trust and a clear process. ~~**Due March 2022.**~~ **June 22 Update: Policy updated. Training program updated. (Sept 22)** ~~4.~~ Risk Management training launched September 2021 and being regularly reviewed and rolled out to staff across the Trust. **On-oing – Dec 22** 5. 6. Quality Improvement program board established.TOR include definition of QI methodology, training needs and project delivery. (Dec 22) 6. Nursing, midwifery & AHP recruitment and retention strategy (Dec 22) 7. Repeat MIAA audit of lessons learnt (Q1 23/24)

		21. Full roll-out/reporting of Tendable app measures 22. Nursing, midwife, AHP and support staff recruitment and retention programme in place. 23. Regular risk management training taking place across the Trust and available to book onto for all Trust staff. Patient safety managers also holding risk management training within the CBU's and specialities. 24. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the SOC 25. Incident reporting and investigation process 26. Ockenden 1 Action plan 27. Ockenden 2 gap analysis 28. Reporting of nosocomial infections and outbreaks 29. Corporate Objectives		4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account 13. Risk management deep dives and self-checks by the Integrated Governance team 14. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the board.		
	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 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.

Strategic Objective 2a: 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 could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts.

Inherent Risk			Risk as at June 2022			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 could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Reduction in the supply of suitably skilled and experienced staff across a number of services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on temporary workforce due to current and	COVID-19 and Recovery • Bronze, silver, gold command structure for oversight and decision making. • Frequency of gold/silver/bronze meetings revised based upon trigger alerts linked to COVID-19 admissions. • Part of C&M hospital cell group monitoring COVID-19 recovery and supporting mutual aid discussions. • Single accountability framework for reviewing CBU areas for development/strengths. • RTT restoration plan being monitored on a weekly basis and reported ~~to gold~~ weekly ~~and~~ to ETM & monthly to FP&I. • Non RTT trackers in place with planned programme of work • Directorate Manager role that is solely responsible for access - providing greater strengthen in governance and compliance. • Access policy for validation of all patients on waiting lists. • Clinical prioritisation of all patients. UEC and Discharges • ED RCA process for breaches • Agreed in-hospital winter plan 2020/21. • Agreed out of hospital (system) winter plan 2020/21. • System wide capacity and flow meeting held twice weekly to review system discharge delivery. • 4 x daily bed capacity meetings to support daily planning. • Additional funding to support UEC winter plans. Workforce • Shaping care together programme. • Comprehensive trust service assessment completed to establish levels of fragility and core drivers	1. The expected outcomes and opportunities of partnership with STHK are still being explored. 2. Need to identify other appropriate stakeholders for clinical services partnerships. 3. Shaping Care Together programme is yet to define preferred option ~~4. The workforce of the Trust does not have the mature level of expertise to ensure QI methodology can be applied.~~ 5. Lack of systematic capacity and demand modelling. ~~6. Sefton Brough is still developing plans for ICP from July 2022~~	**LEVEL 1** (Operational Management) 1. Quarterly Performance, Improvement, Delivery and Assurance (PIDA) Boards – CBU assurance 2. Monthly CBU FPI's in place from April 2022 – CBU assurance. 3. Number of improvement boards in place reporting in via PIDA ○ Theatre Utilisation Board ○ Urgent and Emergency Care Improvement Board ○ Endoscopy Improvement Board ○ Cancer Improvement Board 4. Review of CBU Risk Registers at Risk and Compliance Group. 5. CBU review at Clinical Effectiveness Committee. 6. CBU Governance Meetings in place. 7. Local IPRs in place to monitor performance which are presented at monthly CBU FP&I and quarterly Performance, Improvement, Delivery and Assurance (PIDA). **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 8. CEO's reports to Board 9. Integrated Performance Report (IPR) to SOC, FP&I, Q&S and Workforce 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 ○ Financial position 10. Monthly reports on ~~Covid-19,~~ elective restoration, UEC performance (including Covid) to FP&I. 11. Monthly reports on cancer improvement to QSC 12. Quarterly Joint Performance Meeting (NHSE, STHK and S&O) . **LEVEL 3** (Independent/Semi-Independent)	1. Constitutional standards are not being met 2. Robust plans to deliver the 2022/23 operational plan 3. COVID-19 continues to impact elective recovery and discharge of patients	~~1. Clinical workforce strategy to be completed~~ **Action picked up under SO1.** 2. ~~COVID-19 and recovery~~ Elective recovery plans in place. **June 22 Update: Ongoing. Activity plans for 2022/23 signed off by FPI and submitted. Monthly progress reporting to EC & FP&I. Weekly reporting shared with executive team. Trust participates in C&M elective restoration cell that meet weekly.** 3. Develop cancer improvement plan to address performance across all cancer metrics ~~by Dec 21~~ in line with plan for 2022/23. **June Update: Ongoing. Revised cancer improvement plan for 2022/23 signed off by QSC. Monthly reporting of performance to FPI and QSC. Weekly PTL meetings in place chaired by the ADO, weekly performance meeting in place, chaired by DCOO.** 4. Develop endoscopy Improvement Plan **June update: Endoscopy improvement group meets monthly to discuss all aspects of endoscopy performance. COO in attendance. Weekly and monthly data submissions to C&M. Best performer on points per list in C&M. Added surveillance patients to the waiting list. Working on the TIF bid to support JAG accreditation.** 5. Discharge planning: Improve the effectiveness of discharge processes to support 30% discharges before noon. **June Update: Remains challenging as limited capacity in community. Operating at 60+ RFD each day. Flagged as a concern at CCQRM in May 2022 & June 2022 & asked system partners for support. Meeting being arranged with CCG and COO in June 2022. Daily RFD**

	projected workforce gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties and loss of services. • Loss of market share. • Reliance on other acute providers to support the delivery of clinical services • Loss of ERF funds.	Use of Resources • Use of Resources Programme established to support well led approach for clinical and corporate services. • Quality impact assessments (QIAs) for all service changes that are considered. • Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. Operational leadership • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme		13. NHSI Single Oversight framework and monitoring arrangements 14. CCG monthly quality and performance meetings. 15. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 16. Getting it right first time (GIRFT) programme. 17. Cancer alliance oversee delivery and performance regarding cancer metrics. 18. NHS England / NHS Improvement 19. CQC 20. Internal Audit 21. External Audit.		**meetings and 3 x weekly LLOS meeting take place with system partners.** 6. Working with ECIST to develop a capacity and demand model for UEC by August 2022 7. Theatre Improvement – Theatre Improvement and Productivity Group was relaunched in June 2002 and has identified key opportunities for improvement focusing initially on T&O, Ophthalmology and ENT. These specialty improvement plans will be implemented during 2022/23.
	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.

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

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

RISK ID	2432	Risk Description	If the condition of the Trust estate is not improved then there is a risk to the delivery of high quality safe and effective services and to the experience of patients, visitors, and staff

Inherent Risk			Risk as at June 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	5	20	1	5	5

Risk Description: There is a risk around condition of estates and backlog maintenance issues

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk that essential hospital infrastructure could fail or not be fit for purpose to meet recognised H&S requirements or NHS HBN standards **CAUSE** Lack of capital investment to reduce CIR (Critical Infrastructure risk) backlog **CONSEQUENCE** If our infrastructure fails or has issues there are several consequences which could potentially happen as a result, such as: • injury to patients, staff, visitors and contractors • Fines for non-compliant systems and support • Risk of fire • Death • Loss of trust assets • Public perception	1. Estates asset List & information in place 2. 6 Facet & Condition Surveys undertaken 3. Engineering Safety Systems Group has been established 4. Annual Capital Programme 5. Additional project management and construction capacity secured 6. Trust Green Plan 7. Soft FM services performance management	1. Gaps in asset information 2. Some assets awaiting surveys to be undertaken 3. Need for the development of an Estates Strategy that responds to the Shaping Care Together preferred service configuration option	**LEVEL 1** (Operational Management) 1. Planned Preventative Maintenance (PPM) Programme 2. Minor works response times 3. H&S Committee 4. Water Safety Group 5. Engineering safety Group **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Capital plan 2022 – identifies funding to continue with fire safety and nurse call projects 2. ERIC 21/22 Submission 3. Fire safety action plans for both sites which are monitored at the H&S Group **LEVEL 3** (Independent/Semi-Independent) 1. AE (Authorising Engineer) Appointments 2. AE (Authorising Engineer) Audits undertaken	1. Current PPM Programme does not meet SFG20 - Standard maintenance specification for building engineering 2. Route to securing sufficient capital to address the serious backlog maintenance issues at the Trust	1. Current CAFM system does not have capabilities required for sufficient asset management or the ability to API link to SFG20 standards - Currently in Mobilisation phase site drawings are being uploaded and asset collection commenced in June – Moderate progress made – Target completion date December 2022 2. We have received £3.2m to tackle fire safety issues in 2022/23 and a further £2.6m has been awarded which will be targeted against access control/CCTV and electrical safety issues in 2022/23, CEO is following up with ICS re how the remaining gap will be addressed.

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

Strategic Objective 2c: Major and sustained failure of essential IT systems

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

RISK ID	2411	Risk Description	There is a risk of major and sustained failure of essential IT systems

Inherent Risk			Risk as at June 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	4	2	8

Risk Description: There is a risk that major and sustained failure of essential IT systems

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk of a major and sustained failure of essential IT infrastructure **CAUSE** • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Inadequate investment in systems and infrastructure **CONSEQUENCE** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	1. IM& T Committee Oversight & IT Management Governance 2. Procurement Frameworks 3. Trust Digital Strategy 4. Performance framework and KPI's 5. Cyber Security Response Plan 6. Benchmarking 7. Workforce Development 8. Risk Register 9. Major Incident Reviews 10. Disaster Recovery Policy 11. Disaster Recovery Plan and restore procedures 12. Backup System in place and operational 13. Engagement with C&M Cyber Security Group 14. Cyber Associates Network Membership 15. Business Continuity Plans 16. Care Cert Response Process 17. Project Management framework 18. Change Advisory Board 19. Digital Design Authority 20. Information asset owner / administrator register 21. Cyber Security Provision provided by Mid-Mersey Digital Alliance (MMDA) 22. Monthly Patching Strategy in place 23. Microsoft Defender Anti-Virus in place and actively monitoring for malware, viruses and threats 24. All servers and PC's linked to Microsoft ATP\Defender 25. Regular Cyber Security Comms 26. Quarterly NHS Digital Simulated Phishing Attacks 27. Backup System with backup schedule in place	1. Technical Development of Trust Staff	**LEVEL 1** (Operational Management) 1. IM&T Committee 2. Digital design Authority 3. IT On Call (including Network specific cover provided by MMDA) 4. Risk and Compliance Group 5. Information Governance Steering Group 6. Executive Management Committee 7. Information Asset Owner Framework 8. Benefits Realisation Framework monitoring 9. Cyber Security Action Plan 10. Monthly Cyber Security Assurance Group with MMDA **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Board and Committee Reports 2. Quarterly Digital Strategy Reviews 3. Monthly Cyber Security Reporting **LEVEL 3** (Independent/Semi-Independent) 1. Internal Audit reports 2. Annual Penetration Test and Report 3. Data Security Protection Toolkit Submission 4. Microsoft Unified Support Contract 5. Microsoft Server 2008 Extended Support 6. 24/7 Support Contracts in place for core systems such as EPR, Kainos, VMWare, Dell, etc.	1. Migration from end-of-life operating system ongoing and due to complete in 2022 2. Cyber Essential Certification / Accreditation	1. Implementation of Intrusion Prevention System (IPS) that detects cyber-attacks within the network. (Q2 22/23) 2. ~~Patch My PC deployment for 3rd party app patching.~~ Complete 3. Network Remediation Rollout underway (Ongoing with completion now scheduled for Q4 22/23) 4. Cisco Identity Services Engine Implementation (Now Scheduled for Q4 22/23) 5. ~~Geo-blocking in place for Russia and China internet traffic. Monitoring firewalls for further~~ Complete 6. ~~Microsoft Unified Support Contract In Place~~. Completed 7. Annual Penetration Test (June 2022) 8. PC Network Segregation (to be complete Q3 22/23) 9. Brocade Core Switch replacement (June 2022) 10. VPN Replacement (June 2022)

		28. Care Cert Response Process in Place 29. Role Based Access Control in place across domain and all clinical systems 30. Failover technology in place across Trust VMWare estate 31. Server Network Segregation in place 32. Imprivata Single Sign On In Place 33. Patch My PC in place for 3rd party application patching				

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

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	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Inherent Risk			Risk as at June 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	2	4	8

Risk Description: Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners **CAUSE:** • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to develop and deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to stabilise Fragile Services • Failure to secure sufficient capital support to address significant backlog, and transformational requirements • Failure to ensure alignment of essential co-dependant clinical services • Failure to implement transformational change at sufficient pace • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV / NHS LTP)	• Operational Plan and HCP/ICS financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances Processes • Monthly financial reporting • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSEI annual provider Licence Declarations • Signed Contracts with all Commissioners • Signed SLAs with all partners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group • Increased collaboration across C&M to deliver transformational CIP contribution	• Currently no financial recovery plan that delivers break-even/ addresses drivers of the underlying financial position • National requirement for resubmission of 2022/23 Financial Plans • Lack of medium & long-term financial plan, taking in to account current position and savings from any reconfiguration • Lack of strategic capital plan • E-rostering system not fully utilised across the Trust. • Demand and Capacity process to inform Operational Planning	**LEVEL 1** (Operational Management) • Monthly CBU FP&I meetings now established • Use of Resources Programme Board • Corporate and CBU Efficiency Programme Group (EPG) meetings / CIP Council meetings to be established from June 2022 • Monthly budget holder meetings **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) • Finance & Performance Committee • Audit Committee • Annual Financial Plan • Monthly Finance Reporting • IPR • Annual Accounts • SLR/PLICs update reports • UoR Reports • Internal Audit Programme • National costing returns • Shaping care together programme **LEVEL 3** (Independent/Semi-Independent) • NHS England/Improvement monthly reporting • CQC Reports • CCG Contract Review Meetings • Head of Internal Audit Opinion • External Audit reports inc. VfM Assessment	• Ability to monitor trajectory against financial recovery plan until developed • Demand and Capacity modelling to inform Operational Planning • Premium Rate Pay Control Panel across the CBUs in process of being established • CIP Council in process of being established • Trust PMO capacity to support delivery of CIP, UoR Action Plan, capital business cases, and service transformation	• Collaboration agreement in place with StHK • Develop scenario-based approach to Operational plan/budget setting for 2022/23 – **June update** - Final Plan Re-submission June 2022 • Development of Medium & Long-Term Financial Model & strategic capital plan – **June update** - September 2022 • Development and implementation of monthly financial reporting suite and forecasting model to drive ownership and accountability for performance **June update** – in place from April 2022 – automation opportunities with BI ongoing • Establish processes for Capacity and Demand planning from October 2022. • Establish processes for identifying, implementing, and monitoring delivery of efficiency/productivity (CIP) **June update** – fortnightly CIP Council commencing June 2022 • Management of rostering centralised from April 2022. E-rostering to be fully rolled out in all areas **June update** – two remaining areas by August 2022. • Establish a Premium Rate Pay Control Panel across the CBUs **June update** – commences June 2022 • Analysis of activity in relation to PbR to understand the drivers of changes, market share, and potential solutions **June update** – September 2022 • Seek all possible sources of capital and revenue funding through national bids to support capacity and transformation, including opportunities re co-location of services **June update -** ongoing

	EFFECTS: • Failure to meet statutory duties • External Cash Support Requirements • NHS Single Oversight Framework Segmentation Status increase **IMPACT:** • Unable to deliver viable services • Loss of market share • Regulatory intervention					
	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.

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 June 2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**16**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust 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. Warm Welcome staff induction in place 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 programmes & 360 feedback available to all staff 17. Apprenticeship programmes available to all staff from Level 2-7 qualifications 18. Effective approach to supporting attendance to reduce sickness absence levels.	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. Poor PDR compliance rate 5. E-rostering system not fully utilised across the Trust and limited options for flexible working 6. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management 7. No easy ability for staff to move without full application process ~~8. Failure to meet essential skills training targets~~ 9. Education Governance structure requires revision	**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. Apprenticeship Levy/Programmes 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual 11. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement	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, the implementation of establishment control is progressing at pace and the majority of the preparation work is now complete. Aiming for this to be in place by the **end of December 2021**. **June 22 update:** Nursing workforce plan almost complete and awaiting discussion with Deputy Medical Director to ensure future alignment to medical workforce plan. STAR methodology applied to Urology, next area Obs & Gynae. Intention to roll out to all medical specialties (overseen by Workforce Improvement Group) to understand workforce planning implications for each. New / existing roles to be reviewed as potential resourcing solutions to support clinical workforce plan, starting with Advanced Clinical Practitioner roles. Physician Associates and SAS doctor progression will be included as part of this work. 2. Engagement planned with recent staff appointments (6-12mths) to review Recruitment and Selection process to identify improvements & develop further inclusive approaches Ongoing – expected completion date December 2021. **June 22 update:** PID to be completed by 15th June 2022 3. Alignment of business planning to Job Planning **June 22 update:** Job Planning round to be completed by end of June 2022 4. E-rostering system now being rolled out to remaining departments **June 22 update**: remaining departments due to be completed by August 2022 5. Review of current rostering practice across each area and guidance and support is

		19. Updated Resourcing Plan required and no clinical workforce plan in place 20. Lead Employer progression 21. Internal transfer principles to be explored 22. Core mandatory & essential skills training programmes in place 23. Clinical Education Review undertaken 24. Bespoke and tailored support provided to newly recruited international colleagues. 25. Essential skills training action plan in place to drive compliance and reviewed monthly.		2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		being offered to improve as phase 2 of the benefits realisation. 4 departments identified as pilots for team/self-rostering is now underway **June 22 update:** testing being carried out over the summer holidays as this is a time of peak leave and will be a good test of concept (September 2022 target completion) 6. ~~Agile working group developing principles for hybrid working and review of flexible working policy to be piloted with CMO staff in **July 2021**~~. **Completed** 7. Review of supporting attendance policy with support from NHS England/Improvement to address areas identified as outliers compared to Trust's with lower absences. **June 22 update:** Revised policy being taken to the July JNC 8. Each CBU to have an improvement trajectory for planned reduction in sickness absence and progress to be monitored through monthly PIDA. **June 22 update:** New trajectories being developed for 2022/23. 9. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust **June 22 update:** One consultant now in post. The second role is currently under review following 3 unsuccessful recruitment campaigns with a view to readvertise before September 2022. 10. Internal transfer principles to be explored. There is no easy ability for staff to move without a full application process. T&F group established mid-October 2021 to assess need for transfer SOP with potential qualifying criteria to be determined. **June 22 update:** The work stream has been re-established and initial meeting held. Internal Policy to be finalised during Quarter 2 (22/23), following work through Valuing Our People through Inclusion Group ~~Essential Skills Risk under review and action plan to be implemented to achieve Trust target.~~ **Completed** 11. Clinical Education Risk & Governance structure & processes under review by Executive Team **June 22 update:** Proposal due to be submitted to Executive Committee by end of July 2022 12. PDR action plan in place to drive improved compliance over the summer 2022 period (typical trend for reduced compliance) and progress monitored monthly **June 2022 update:** 55 staff with no PDRs over last 3 years to be contacted and PDRs arranged by July 2022. Respective Executive Directors to receive break down of all staff

						with no current PDR and follow up directly from end of June 2022.
	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 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 June 2022**			**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.	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 oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance, and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee. 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training. ○ PDR completion. ○ Sickness rates. 2. Turnover. 3. Vacancies. 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 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 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. **June 22 update:** Focus now on introducing Staff Voice Partnership (Listening Plan) from end of June 2022 which will include leadership development to aid effective listening and re-launch of Board to Ward from August 2022. 2. Talent management/succession planning framework – participation in the Workforce Improvement Group Transformational Leadership workstream (Operations Career Development Framework). **June 22 update:** Pilot roles introduced in the Planned Care Operations structure to be evaluated. Evaluation to inform career development pathway and design of corresponding leadership development offer. Additionally, core leadership and management offer is currently under review to ensure compassionate leadership behaviours and just & learning principles are embedded going forward with a view to launch in January 2023. 3. 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. **April 22 Update:** This has been superseded by funding received nationally to support development of system leaders across the Sefton Place. To commence September 2022 with preparatory work now underway. ~~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).~~ **June 22 update:** Board to Ward will be relaunched as part of the initiatives re: the

		21. Refreshed and introduced groups within the structure to support delivery of Our People Plan • 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. 25. A reciprocal arrangement in place through the Mediation Network accessed by the Trust on a case-by-case basis where appropriate. 26. The Trust has 7 trained Schwartz Round facilitators as well as access to a further 3 as part of Sefton Place partnership.		4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education NorthWest 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		new Staff Voice Partnership (Listening Plan) from end of June 2022 (see action 1) 5. Work programmes identified by the Valuing Our People Inclusion group (VOPIG) from feedback from staff survey to improve staff engagement score. Quarterly Staff Survey to be launched on 1st July and regularly monitoring the impact of the VOPIG programme of work. **June 22 update:** Updated Our People Plan action plan presented to WFC and SOC in April 2022. VOPIG will oversee progress and have identified 3 priority areas of focus – Health and Wellbeing, Listening Plan and EDI. 6. Revised proposals for strengthening engagement presented to the Executive Committee for review in March 2022. **June 22 update:** The Trust will introduce the Staff Voice Partnership (Listening Plan) from end of June 2022. In addition, there will be an evaluation of the OD programmes currently ongoing in Maternity Services (responding to Ockenden report) with a view to roll out the similar approach across the Trust starting with 'hotspot' areas/staff groups from August 2022. 7. PDR action plan in place to drive improved compliance over the summer 2022 period (typical trend for reduced compliance) and progress monitored monthly **June 2022 update:** 55 staff with no PDRs over last 3 years to be contacted and PDRs arranged by July 2022. Respective Executive Directors to receive break down of all staff with no current PDR and follow up directly from end of June 2022.
	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.

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:** Director of Transformation (CEO)

RISK ID	**6**	**Risk Description**	**If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population.**

Inherent Risk			**Risk as at June 2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	5	**20**	3	5	**15**	2	5	**10**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**

RISK
If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population.
 	
CAUSE
• Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire
• Lack of system-wide workforce planning to address reduction in supply of suitably skilled and experienced staff.
• Emerging Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach
• Complex health economy
• Lack of clarity about additional investment to address sustainability challenges
• Lack of public and staff 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.
• Failure to deliver safe, high quality patient care and experience in the most appropriate environment
• Financial unsustainability due to increased costs
	1. Whole system engagement to address the required whole system change
	2. SCT Programme Plan including key milestones to enable public consultation
	3. Robust system governance structure in place to support the Shaping Care Together (SCT) programme
	  • Programme Board
	  • Operational delivery groups
	  • Clinical Leaders Group
	4. Strategic partnership (ALTC) established with StHK
	5. Comprehensive trust service assessment completed to establish levels of fragility and core drivers
	6. Member of Sefton Integrated Care Partnership (ICP)
	7. Member of the Cheshire & Merseyside Acute Provider Collaborative.
	8. Patient and Public Engagement strategy for SCT programme
	9. Comprehensive due diligence completed, and documentation library created.
	10. Quality and equality impact assessments completed and reviewed in advance of any changes to Trust service provision.
	11. System Equality Impact Assessment process established.
	12. Cheshire and Merseyside Integrated Care System governance structure
		1. Clear alignment between Shaping Care Together programme, System Management Board & Sefton ICP
		2. Sefton Brough is still developing plans for ICP from June 2022
		3. Lack of established Patient & Public Reference Group
		4. Expected outcomes and opportunities of partnership with StHK are still being explored
		5. Identification of other key stakeholders for clinical services partnerships where StHK is not appropriate
		6. Shaping Care Together programme is yet to define preferred option
		7. Clinical workforce strategy not fully developed.
		8. Risks relating to current estates and infrastructure continues to be defined
		9. CCGs are still defining their commissioning and transformation priorities for 22/23
		10. Cheshire and Merseyside Acute provider collaborative have not yet identified key clinical pathways for system collaboration.
			LEVEL 1
			(Operational Management)
			
			1. CBU FP&I (Monthly, Performance, Improvement, Delivery and Assurance (PIDA) Boards (Quarterly), with suite of measures.
			2. Ongoing review and management of 'fragile services'.
			3. Collaboration Senior Team Meetings (StHK & S&O Trust) reviewing immediate priorities and opportunities
			4. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board.
			5. Patient and public engagement strategy monitored at Programme Board.
			6. Equality Impact Assessment outcomes monitored at SCT programme board.
			7. Haematology Assurance Group – partnership meeting to monitor improvement delivery
			8. Ophthalmology Improvement Group – partnership meeting to develop and monitor system improvement plan
			9. North Mersey Stroke Board – partnership board to develop and implement case for change, engagement & operational plans
			
			LEVEL 2
			(Reports and Metrics monitored at assurance committees and/or Board)
			1. CEO's reports to Board
			2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including:
			  ○ Mortality
			  ○ Incident data
			  ○ CQUINS
			  ○ Operational performance data
			  ○ Complaints and compliments
			3. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group
			4. Sustainability and collaboration update to Strategy and Operations Committee
			5. Quarterly Joint Performance Meeting (NHSE, StHK and S&O)
			6. LUHFT & S&O Partnership Board
				Development of good working relationships with the new Primary Care Networks
				
				Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1 July 2022
					1. SCT Programme to develop Models of Care and define preferred option.
					June 22 Update: Models of Care developed, and initial options assesses against hurdle criteria. Further options are now being considered following public and staff consultation.
					2. Establish Finance and Capital Assurance Group with alignment to the System Management Board
					June 22 Update: No further update - FCA group established – DoFs have met and agreed mitigation approach to be concluded by July 2022
					3. Continue to develop collaboration opportunities with StHK
					  a. ~~Paediatric Dietetic model developed by April 2022~~ Completed
					  b. Establish Therapies Assurance group by February 2022 – March update - meetings in place
					June 22 Update – Group is now established, and a work programme is being developed. This will be completed for July 22
					  c. Ophthalmology clinical working group established to support clinical workforce recruitment challenges. Workplace to be developed by July 22
					4. Continue North Mersey Stroke Programme with implementation date of September 2022
					June 22 Update Implementation date formally agreed in writing for 19 September 22
					5. Continue to support Sefton ICP task and finish group with Bill due to come into effect on 1st July 2022
					6. Develop a North Mersey Ophthalmology Steering group supported by local CCGs – March 2022.
					June 22 Update Meeting delayed due to system operational pressures. Now booked for 25 May 22

	• Poor estate utilisation due to inability to fully reconfigure services • Failure to provide acute core services to our population • Potential impact on neighbouring organisations if core acute services can no longer be delivered by the Trust • Reliance on other acute providers to support the delivery of clinical services • Reputational damage			**LEVEL 3** (Independent/Semi-Independent) 1. Southport, Formby & West Lancashire Joint Committee 2. Participation in the C&M ICS leadership and programme boards 3. Active member of Sefton Integrated Care Partnership (ICP) 4. Active Member of the Cheshire & Merseyside Acute Provider Collaborative & supporting transformation/improvement work stream. 5. Collaborative working with CCGs to develop commissioning and transformation priorities for 22/23 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. Internal Audit 10. External Audit.		7. Continue to develop Liverpool University Hospitals FT relationship with a particular focus on the SLAs already in place. A Partnership board has been created and the first meeting took place May 22 and a work schedule is now in development and will be discussed in the July22 meeting.
	.					
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve

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

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO127/22**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Management Team		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance and 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 22/23 National Priorities 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, with the exception of the Finance section, has a Statistical process Control (SPC) chart and commentary.

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

Recommendations

The Strategy and Operations Committee is asked to receive the Integrated Performance Report (IPR) detailing Trust performance in May 2022, unless otherwise stated.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
✓ **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:**
Katharine Martin, Performance & Delivery Manager	The Executive Management Team

Southport and Ormskirk Hospital NHS Trust

Strategy & Operations Committee - Integrated Performance Report

Performance Summary

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

Quality - reflects those metrics aligned to Trust Objective – Care & Safety

Operations - Trust Objective – Service

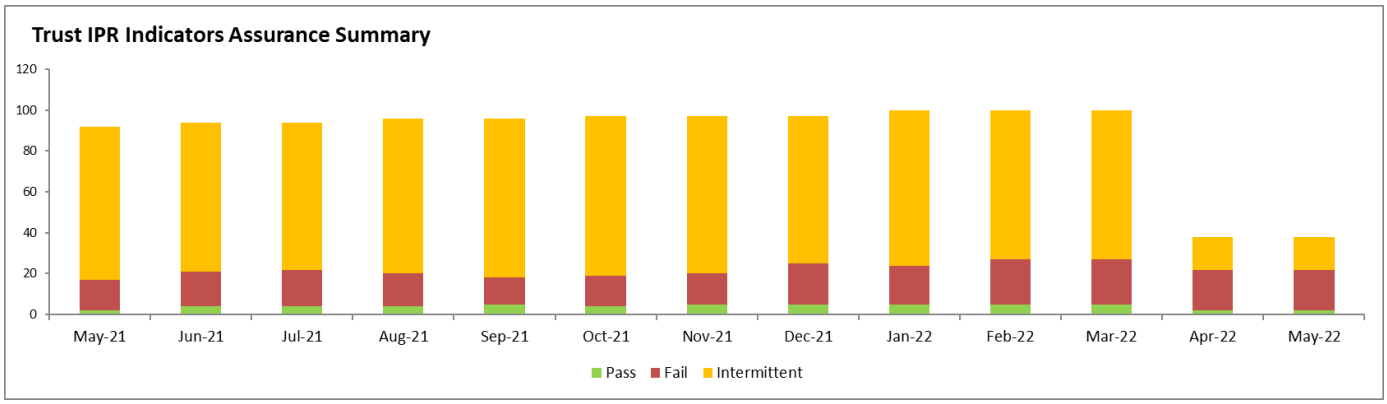
Finance - Trust Objective – Financial performance and productivity.

Workforce - Trust Objectives – Supporting our workforce and Open and honest culture.

The indicators and targets contained within the Trust Integrated Performance report (IPR) were reviewed at the end of the previous financial year. These changes have been approved through the Assurance Committees and Strategy and Operations Committee and this paper reflects the changes implemented, which includes a reduction to the number of indicators being reported in 2022/23.

Finance indicators are not being reported using SPC.

The indicators assured this month are Percentage of Patient Safety Incidents - Moderate/Major/Death(related) and Mandatory Training.



Southport and Ormskirk Hospital NHS Trust

Harm Free, Infection Prevention & Control, Maternity, Mortality and Patient Experience

The CQC rated the Trust as **requires improvement** overall following its inspection in July/August 2019. The caring domain was rated as **good** and well-led, safety, responsive and effective domains rated as **requires improvement**. An unannounced CQC visit to Medicine and Emergency Care in March 2021 provided overall positive feedback with 9 'should-do' recommendations.

There were no Never Events reported in May 2022 (2022/23 YTD = 1).
There were no cases of MRSA in May. (2022/23 YTD = 0).
There were two C. Difficile (CDI) positive cases reported in May 2022 (2022/23 YTD = 7).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2022 was 95.2%. This is based on 99.35% for Registered Nurses and 90.41% for Un-Registered Nurses.
There was one category 3 hospital acquired pressure ulcer reported in May (2022/23 YTD = 2).
There were 59 patient falls in May of which two resulted in moderate harm (2022/23 3 Falls with Harm).
All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) increased to 88.9% in May, from 87.9% in April.
The % of complaints responded to within timescales has continued the improving trajectory, achieving 77.8% against the 80% target in May.

Operational Performance

Overall Accident and Emergency performance for May 2022 was 76.8% (Adults ED 53.15%, Paeds ED 95.76% in May). This compares favourably with peers, with an England average of 73%, Northwest 71.2% and Cheshire & Mersey 71.9%. The Trust is the second highest performer in Cheshire and Mersey. Combined attendances for SDGH and ODGH were 8,289 in May compared to 7,451 in April and 8340 in May 2021. 47.5% of Ambulance Handovers occurred within 15mins, an increase on April (40.6%) but behind the 65% target. Similarly, 76.6% of Ambulance Handovers were within 30mins, compared to 65.5% in April and short of the 95% target. 29 Ambulance Handovers breached 60mins in May, a reduction on the 97 reported in April.

Performance against the 62-day cancer standard was below the target of 85.0% in month (April 2022) at 48.3%. This is a deterioration on the March position of 70.5%. The Trust is an outlier for this indicator, with the England average of 65.2%, Northwest 65.5% and Cheshire & Mersey 70.5% (April 2022). The Trust failed to achieve the 96% target for the 31-day target in April 2022 with 91.3% performance in month (March 95.9%). By way of comparison, in April, the England average of 92.8%, Northwest 93.9% and Cheshire & Mersey 95.3%. The 28 Day Faster Diagnosis Standard failed to achieve the 75% target in April, achieving 66% (March 67%).

The average daily number of stranded patients in May 2022 increased to 193 from 184 in April. The number of super-stranded patients also increased, from an average of 60 in April to 71 in May.

Operational Performance continued

The Criteria to Reside metric is in excess of the 35 target, averaging 52 in May, but an improvement on the 56 reported in April. All these metrics were impacted by delays in care packages, availability of community beds and care home capacity.

The 18-week Referral to Treatment target (RTT) was not achieved in May 2022 with 74.9% compliance, (77% in April), against the 92% target. The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 61.3%, Northwest 56.3% and Cheshire & Mersey 59%.

There were 290 52+ week waiters at the end of May, an increase on the 192 reported in April, with 46 patients waiting longer than 78 weeks, the target is to achieve 0 by the end of April 2023. There remained no 104-week waiters. The Trust is the fifth best in Cheshire & Mersey, with only Alder Hey, Clatterbridge, Walton Centre and Liverpool Heart & Chest slightly better.

The Diagnostic target was not achieved in May 2022 with 43.6% patients waiting longer than 6 weeks, an improvement on the previous month (48.6%) against a target of 1%. The Trust is an outlier for this standard, based on the latest published data (March 2022), the England average was 24.8%, Northwest 25% and Cheshire & Mersey 22.6%.

The Covid-19 crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust is reporting a £3.6m deficit at Month 2 in line with 2022/23 Plan.

The updated 2022/23 Plan sets out a £14.1m deficit after applying:

- £5.3m ERF Income
- £10.8m CIP (3.5%), including ICS Stretch Target of £3.0m profiled into Q4
- £1.5m national funding for Excess Inflation
- £1.6m additional non-recurrent System Allocation
- £0.3m additional System Allocation for UEC pressures

Pending confirmation of ERF calculations and System performance, the Trust has assumed 100% achievement of ERF funding in M1 & M2.
ERF performance is highlighted as a risk to delivery of 2022/23 Plan in view of continued operational pressures and winter escalation experienced into 2022/23.

CIP - The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target profiled into Q4. The Trust is reporting delivery of CIP to M2.

Finance Continued

Cash - The cash balance at the end of May was £11.5m. A reduction of £1m from April's position. Regional cash support will be required from December as the Trust is operating with a planned £14.1m deficit in 2022/23.

BPPC – The Trust is currently achieving 95% against a 95% target. Note the NHS target has fallen behind and corrective action has been taken by building in an additional two NHS payment runs per month.

Capital - The agreed 2022/23 capital plan is shown in Section 7. This totals £12.9m and includes agreed public dividend capital of £3.2m for fire safety, and £2.6m for Backlog.
National bids for CDC (£4.2m Community Diagnostic Centre) and TIF (£5.5m Targeted Investment Fund – endoscopy investment) are due to be submitted to NHSEI by July 2022.

Workforce

Personal Development Review compliance has reduced in May to 72.9% against the 85% target. Performance in April was 74.1%. Mandatory training compliance remains ahead of target and was 88.4% in May. The 90% stretch target for Mandatory Training will be implemented from June 2022.

In month overall sickness decreased to 6.3% from 7.5% reported in April. The rolling 12-month figure remains 7.2%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness remained static at 5.4%, with the reduction in overall sickness being attributable to a reduction in Covid-19 absence.

The overall Trust vacancy rate has decreased marginally to 10% in May, from 10.2% in April, against the 7.4% target. In-month Staff turnover has increased marginally to 1% in May from 0.9% in April (target 0.83%).

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Strategy & Operations Committee Report

May 2022

Guide to Statistical Process Control

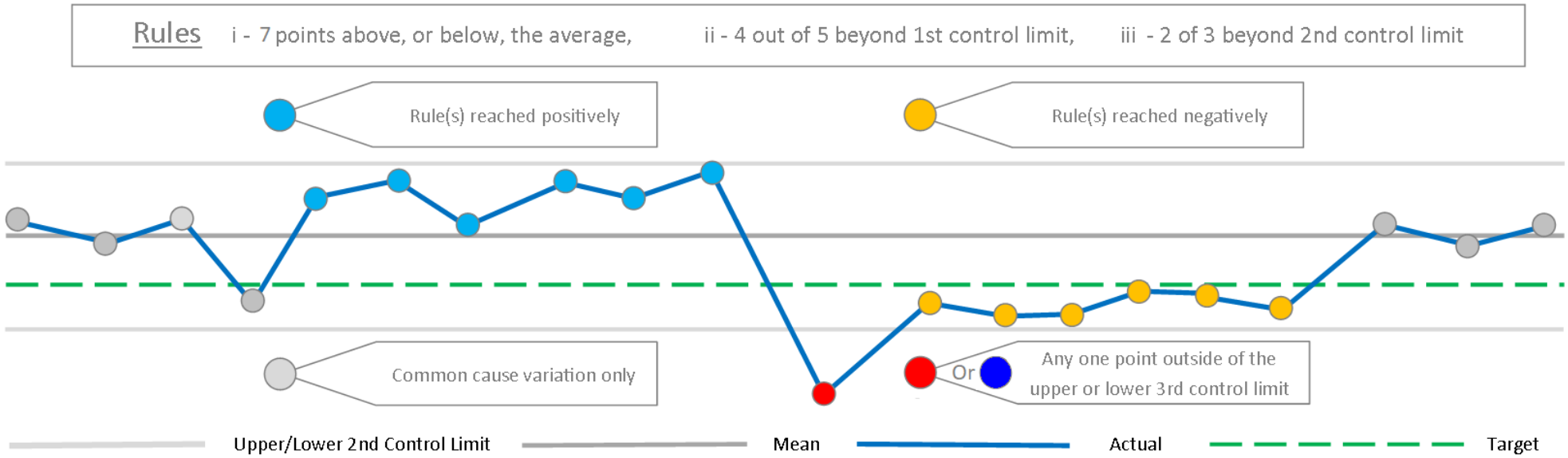
Southport and Ormskirk Hospital NHS Trust

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

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

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

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



Executive Summary

	Improvement	VariationCommon	Concern
Consistently Passing		Mandatory Training Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	
Inconsistent	Safe Staffing TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	31 day treatment Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month C-Diff E. Coli Falls - Moderate/Severe/Death Hospital Pressure Ulcers - Grades 3 & 4 MRSA Never Events No Criteria to Reside - Avg No of Patients Patient Falls - Trust Sickness Rate Staff Turnover	Stranded Patients (>6 Days LOS) Super Stranded Patients (>20 Days LOS)
Consistently Failing	Complaints - % closed within 40 working days Sickness Rate (not related to Covid 19) - Trust	28 Day Faster Diagnosis Standard 62 day GP referral to treatment E-Discharges within 24hrs Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall Outpatient Letters to GP's within 7 Days Trust Vacancy Rate – All Staff	% of Patients spending 12+ Hours in ED - Trust 52 Week Waits Accident & Emergency - 4 Hour compliance Ambulance Handover Over 60 Mins Ambulance Handovers - % within 15 Mins Ambulance Handovers - % within 30 Mins Diagnostic waits Number of Patients spending 12+ Hours in ED - Trust Personal Development Review Referral to treatment: on-going Sickness Rate (Rolling 12 Month) Stroke - 90% Stay on Stroke Ward

Quality

Harm Free

Safe Staffing

Issues
• The Safe Staffing indicator is showing special cause improvement and has increased further in May to 5.2% ahead of target.
• Care Hours per Patient Day (CHPPD) has increased in May and continues to be assured.

Management Action
• Safer staffing remains in the 90%+ and continues to rise due in part to the success of the International Nurse recruitment programme.
• There has been additional staff required to support some ward areas with challenging patients which has given rise to the safer staffing figures also.
• Care hours per day has also increased again due to the increase in staffing within ward areas. Again once staffing establishments stabilise so should the care hours per day.

Patient Falls / Falls - Moderate/Severe/Death

Issues
• Both patient falls and falls resulting in moderate or worse harm are intermittent both in terms of their assurance and variation.
• Patient falls have reduced in May and are below target.
• Two falls resulting in harm were reported in May which is above target but marginally below average.

Management Action
• The Trust falls meetings have been reinstated in May, chaired by the Assistant Director of Nursing for Medicine and Emergency Care.
• The Trust is organising an education day for the falls champions to provide further skills and knowledge that can be disseminated to their respective wards.
• Additional training has been completed at ward level and also at education days (older peoples day, preceptee workshops, student education days).
• The essential job specific falls training is currently a one-off session. Clinical competency working group have agreed to make this three-yearly.
• We are reviewing the enhanced level of care documentation to support staff in identifying those that need additional support.
• The roll out of the Flojac training and associated competency has started up again on the Southport.
• A proportion of the red assessment walking frames ordered in August have finally been delivered to support those patients who do not have their frames with them or require an assessment due to deterioration in their mobility.
• A review of the falls policy has been completed and signed off by the Falls Group – it has been sent to health and safety committee for review.
• We have pulled together a working group with the Therapy services to launch a deconditioning project on the wards.

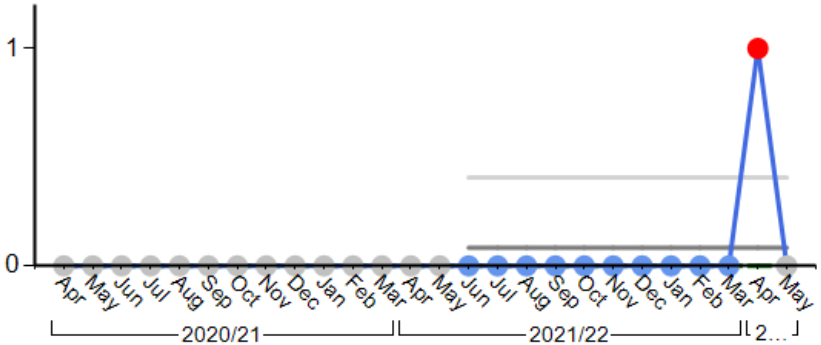
Pressure Ulcers

Issues
• Category 3 Hospital Acquired Pressure Ulcers is performing statistically as expected.
• Hospital Acquired Category 3 Pressure Ulcers are in line with the target with 1 reported in May.

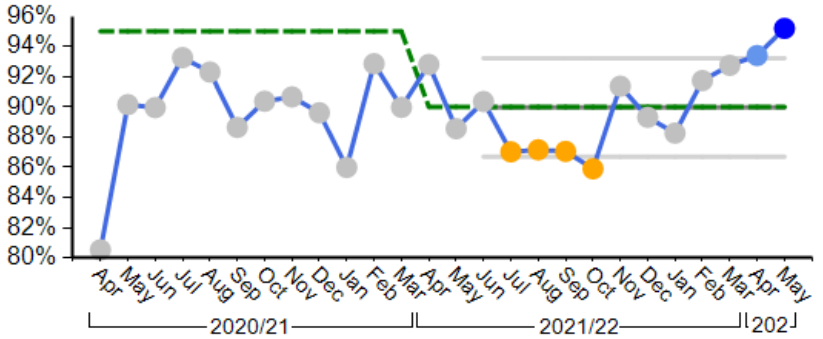
Management Action
• The Tissue Viability Team have undertaken a targeted approach to training (Talk for 10), both focusing on the wards reporting the highest number of pressure ulcers and also the specific issues identified on those wards, for example heel care.
• Laminated training materials are available on the wards to support the staff to correct differentiate pressure damage from moisture lesions.
• The Matrons and link nurses are supporting this training.
• Investigations into some hospital acquired pressure ulcers have identified issues with risk assessment documentation. This has been a focus for targeted training.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	May 22		0	1	Apr 22	0	1	
Safe Staffing	90%	95.2%	N/A	May 22		90%	93.4%	Apr 22	90%	94.3%	
Hospital Pressure Ulcers - Grades 3 & 4	1	1	1	May 22		1	1	Apr 22	12	2	
Patient Falls - Trust	63	59	59	May 22		63	65	Apr 22	756	124	
Falls - Moderate/Severe/Death	1	2	2	May 22		1	1	Apr 22	17	3	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.6%	5	May 22		2.1%	0.7%	Apr 22	2.1%	0.6%	

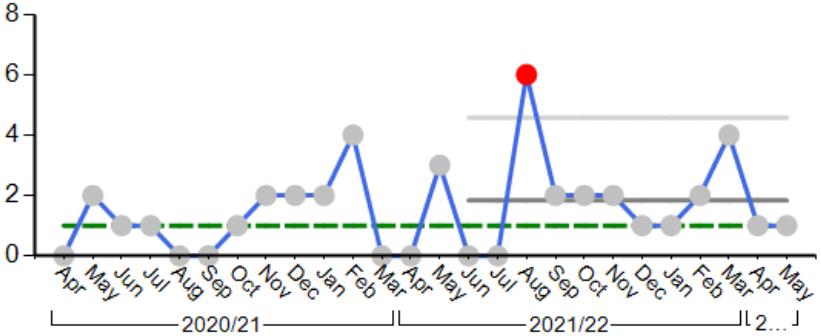
Never Events



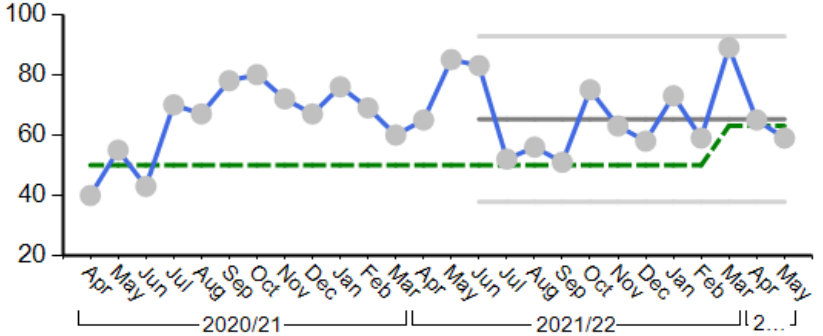
Safe Staffing



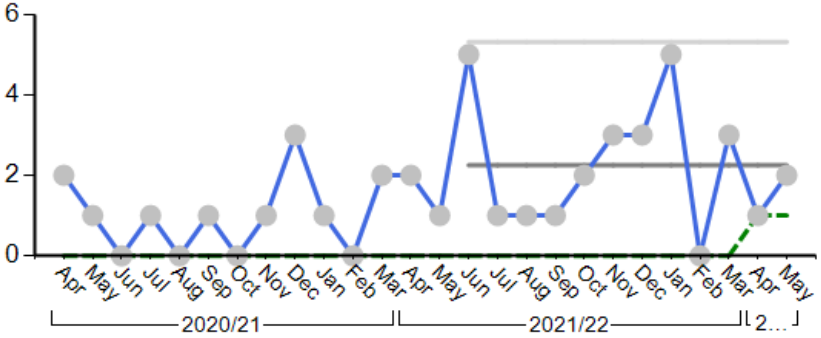
Hospital Pressure Ulcers - Grades 3 & 4



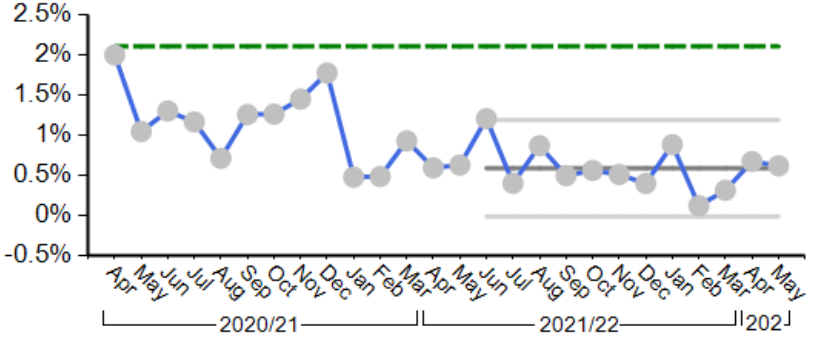
Patient Falls - Trust



Falls - Moderate/Severe/Death



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



Quality

Infection Prevention and Control

C-diff

Issues
• There was a reduction in the number of c-diff infections reported in May, with 2 reported cases. This is less than half the number reported in April and below target.
• Performance remains statistically as expected.

Management Action
• One Hospital Onset Hospital Acquired case reported. The RCA is currently underway.
• One Community Onset Hospital Acquired case reported. The RCA has been completed and identified antibiotic prescribing was not compliant with the Trust formulary. These issues are being reviewed by the Medical team and the Antibiotic Pharmacist with feedback being provided as necessary.

E-Coli

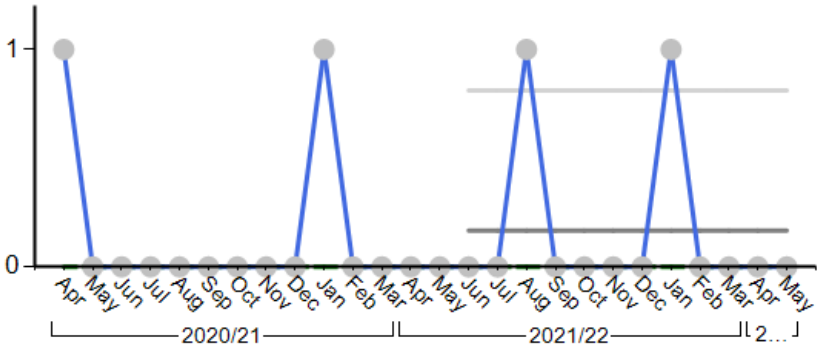
Issues
• Two Hospital Onset Hospital Acquired (HOHA) and 1 Community Onset Hospital Acquired (COHA) cases were reported in May.
• Performance in May remains statistically as expected but is below target.
• Two of the HOHA cases were related to UTI's.

Management Action
• Each of the patients were reviewed and treated in collaboration with the patient's medical team and the Microbiologist.
• Internally the Trust is continuing to consider and take actions to reduce UTIs and CAUTIs - this includes identification and treatment of UTI as well as ensuring adequate hygiene and nutrition, and catheter care and maintenance.

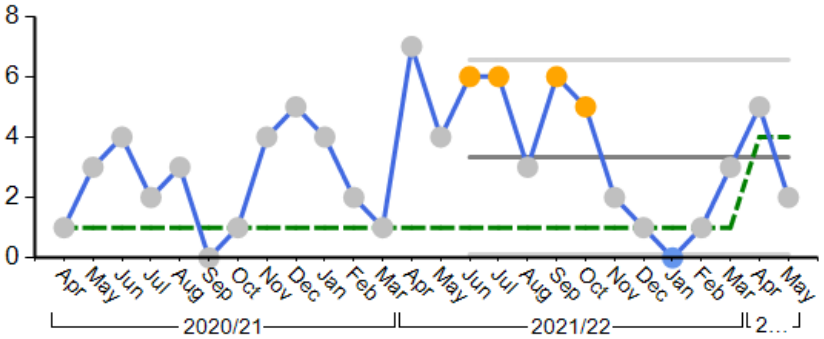
No MRSA infections were reported in May.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	May 22		0	0	Apr 22	0	0	
C-Diff	4	2	2	May 22		4	5	Apr 22	49	7	
E. Coli	4	3	3	May 22		4	5	Apr 22	51	8	

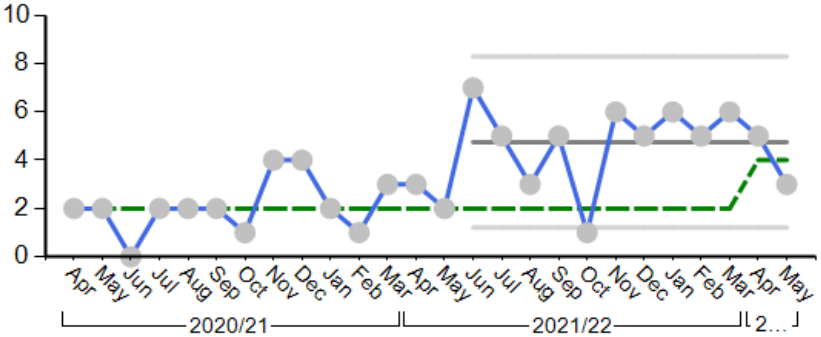
MRSA



C-Diff



E. Coli



Quality

Patient Experience

Complaints - % closed within 40 working days

Issues
• The indicator continues to fail its assurance measure but is showing special cause improvement and is at the highest level since February 2021.

Management Action
• The step-by-step guide to managing a complaint has been developed and will be taken to June's CBU Governance meetings.
• Complaints training is being provided at the next ward manager / matron away day at the end of June 2022.

Friends and Family Test (FFT)

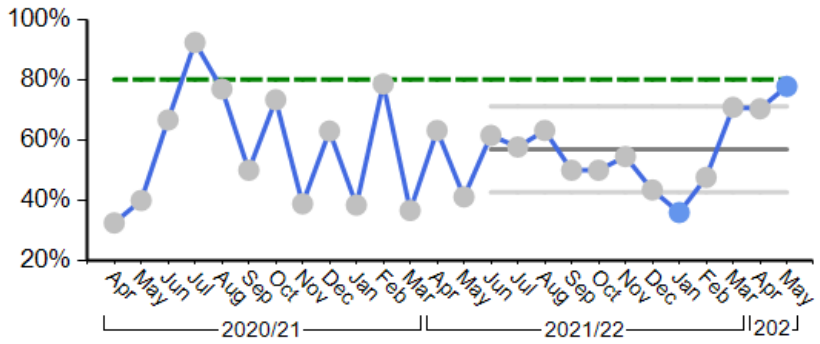
Issues
• The Trust overall Friends & Family Test continues to fail the assurance measure and although this has increased by 1% in May, performance remains below the target.

• The experience of long waiting times in both A&E departments continues to cause a higher number of negative responses and comments.

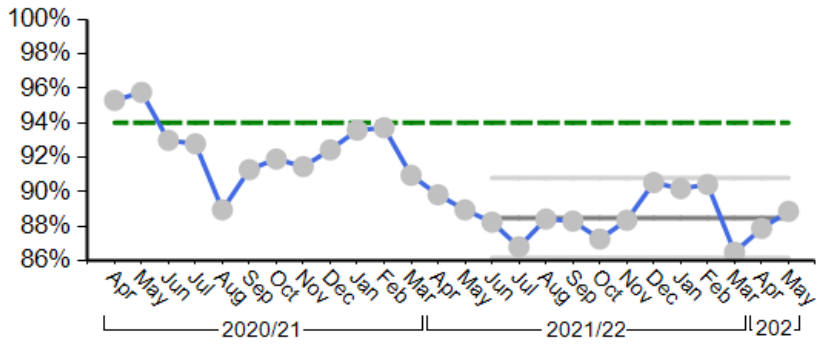
Management Action
• The profile of FFT continues to be raised as a valuable mechanism for receiving up-to-date patient feedback.
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement group where CBU updates and actions to improve FFT are provided.
• Areas continue to review comments to identify any emerging themes or trends to inform a 'You said, we did' approach to improvement.
• FFT results are managed at ward/department level through a performance review process.
• Improvement work continues on the actions identified from the 2020 National Inpatient Survey results.
• Work is ongoing to improve FFT responses in A&E, including an enhanced PALS officer role in Adult A+E, volunteer recruitment and redeploying additional staff to support flow at peak times.
• The local Maternity Voices Partnership meeting has now been reinstated and will provide further opportunity to gather feedback from Maternity patients.
• Work continues on the actions identified from the 2021 Maternity Survey results.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	77.8%	N/A	May 22		80%	70.4%	Apr 22	80%	72.2%	
Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	88.9%	N/A	May 22		94%	87.9%	Apr 22	94%	88.4%	

Complaints - % closed within 40 working days



Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall



Operations

Access

A&E

Issues
• All metrics relating to A&E performance are failing their assurance measures and showing special cause concern.
• The Trust remains challenged against the 4hour standard against attendances 1% higher than the same period 2019/20, with over 80% of attendances categorised as majors patients.
• The Trust remains in the top quartile nationally for ED performance. Significant pressures remain across all ED's in May 22.
• Paediatric A&E saw a large rise in attendances.
• Whilst 9.5% of patients spent longer than 12 hours in the department (777 patients), this is an improvement on the 12.5% reported in April.
• A&E performance impacted by high bed occupancy levels, contributed to by IPC measures, surges in attendances and a requirement for all specialty reviews to be undertaken in A&E.

Management Action
• All patients have multiple specialty reviews undertaken in ED to ensure that admission is clinically required, and all escalation areas have remained open.
• Several actions underway to improve performance, detailed in the Urgent & Emergency Care Update paper, including piloting of frailty and SDEC pathways, review of triage model, 3x daily huddles and review of IPC measures.

Ambulance Turnaround Times

Issues
• Both metrics failing their assurance measure and showing special cause concern but demonstrating improved position in May.
• Ambulance arrivals were 20% lower in May than May 2019/20.
• Challenges continue with timely release of cubicles to enable crews to handover promptly, high numbers of patients awaiting admission who remain in ED until an inpatient bed becomes available. The impact of IPC cleaning requirements also remains.
• Reduced NWAS ALO availability in May due to planned leave and sickness.

Management Action
• Several actions ongoing to address ambulance performance and minimise any risk of harm. These are detailed in the Urgent & Emergency Care Update paper and include introduction of handover checklist and NWAS clinical criteria for SDEC Medical.

Referral to Treatment

Issues
• The Referral to treatment: on-going indicator continues to fail assurance and shows special cause concern with a 2.1% deterioration in May.
• The number of 52-week waits has increased significantly and is above the trajectory. The Trust accounts for 1.5% of total waiting list for C&M, an improvement from last month.
• SOHT 5th best Trust across C&M with Alder Hey, Clatterbridge, Walton Centre and Liverpool Heart & Chest slightly better.
• There were 46 78-week waits at the end of May.
• Conversion of surveillance scopes continues to impact waiting list.
• Overall elective activity achieved 89% of plan in May, 11% behind target but a 4% improvement on April.
• May activity impacted by staffing due to sickness and annual leave, with key areas of under-performance clinical haematology, ophthalmology, and gynaecology.

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• Potential use of ring-fenced beds at SDGH and opportunity of HBS insourcing for T&O patients. Recovery for this specialty expected July 22.

• Active recruitment for Ophthalmology and system transformation project.
• Gynaecology redesign and recruitment complete – recovery expected July 22.
• Urology – new rapid diagnostic pathway to be implemented August 2022.

Diagnostics

Issues
• The Diagnostic Waits indicator is failing assurance and showing special cause concern.
• Performance against the 1% target has improved in May to 43.6%.
• Diagnostic scopes over-performed in May, delivering 127% against the plan.
• Scans underperformed in May, delivering 87.7% of the plan.
• Impact of sickness within Radiology in May.
• Workforce capacity challenges within MRI, CT and non-obstetric ultrasound.

Management Action
• Workforce solutions under review for Scopes including review of job plans to manage High risk FIT process.
• New templates set up in MRI to provide enough capacity to meet targets and plan for 22/23, in place from mid-June 2022)
• New templates for CT and ongoing recruitment. Use of Walton Neuro for 1 list per week.
• Workforce review for non-obstetric ultrasound being undertaken.

Stroke

Issues
• The indicator is failing assurance and showing special cause concern and is at the lowest level since February 2021.
• Performance against the 90% stay on a Stroke ward continues to be challenged and has declined from 41.4% in March to 33.3% in April.
• Compliance in April has been impacted by consistently high levels of attendance to the Trust which has resulted in bed capacity issues and therefore has had an impact on the ability to maintain at least 1 ringfenced Stroke bed. Also impacted by Stroke patients testing COVID positive and so being unable to admit directly to Stroke ward if no available side room.
• Compliance has been challenged by late referrals to the Stroke team and late diagnosis. These accounted for 4 of the 22 breaches. 2 were avoidable.

Management Action
• The Stroke Operational Group continues to focus on quality and pathway improvements
• Collaborative work with LUFT continues as part of the ‘North Mersey Stroke Transformation’ pathway. An implementation date of 19th September has now been formally agreed for the S&O patient cohort and the FBC is due to go to the relevant boards in July 2022.
• In the interim Stroke Nurses continue to provide ad-hoc teaching in ED to support earlier diagnosis.
• Bed meetings take place 4 x daily where a plan for Stroke admissions, and a contingency where there is a lack of ringfenced bed, is established.

TIA

This indicator shows special cause improvement and has achieved 100% compliance in May as it reports on validated TIA referrals only. Work is ongoing to validate the referrals for 2021/22.

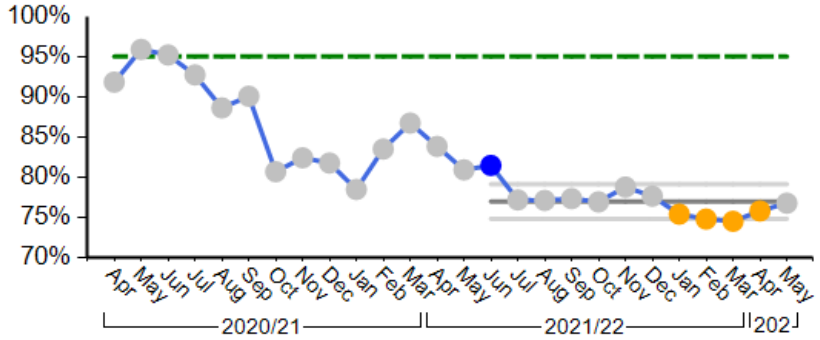
Discharge Communications

Issues
• Both indicators are failing their assurance measures, but current performance is statistically as expected.

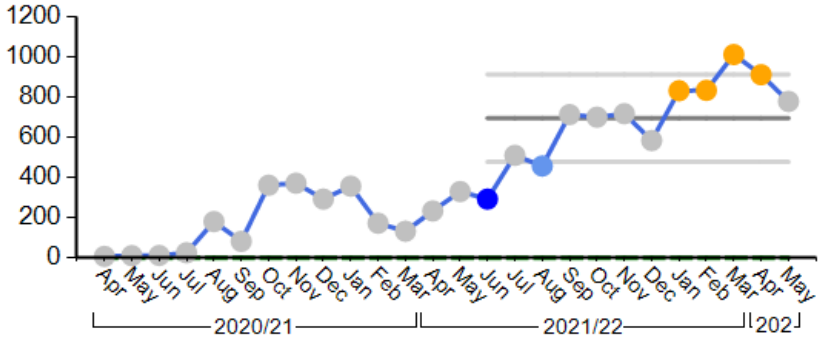
Management Action
• Work is underway to understand the data and understand the specialities and factors impacting the ability to achieve the target.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	76.8%	2554	May 22		95%	75.8%	Apr 22	95%	76.3%	
Number of Patients spending 12+ Hours in ED - Trust	0	777	N/A	May 22		0	910	Apr 22	0	1687	
% of Patients spending 12+ Hours in ED - Trust	2%	9.6%	N/A	May 22		2%	12.5%	Apr 22	2%	10.9%	
Ambulance Handovers - % within 15 Mins	65%	47.5%	627	May 22		65%	40.6%	Apr 22	65%	44.2%	
Ambulance Handovers - % within 30 Mins	95%	76.6%	279	May 22		95%	65.5%	Apr 22		71.3%	
Ambulance Handover Over 60 Mins	0	29	29	May 22		0	97	Apr 22	0	126	
Diagnostic waits	1%	43.6%	3084	May 22		1%	48.6%	Apr 22	1%	46.1%	
Referral to treatment: on-going	92%	74.9%	3258	May 22		92%	77%	Apr 22	92%	75.9%	
52 Week Waits	104	290	290	May 22		116	192	Apr 22	0	242	
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	0.5%	12	May 22		1%	0.7%	Apr 22	1%	0.6%	
Stroke - 90% Stay on Stroke Ward	80%	33.3%	22	Apr 22		80%	41.4%	Mar 22	80%	33.3%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	100%	0	Apr 22		60%	81.8%	Mar 22	60%	100%	
Outpatient Letters to GP's within 7 Days	85%	68.2%	3358	Apr 22		85%	70.5%	Mar 22	85%	68.2%	
E-Discharges within 24hrs	85%	78.7%	294	May 22		85%	75.9%	Apr 22		77.3%	

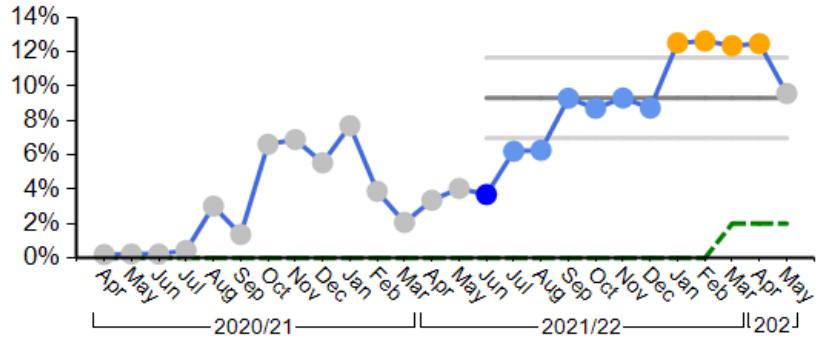
Accident & Emergency - 4 Hour compliance



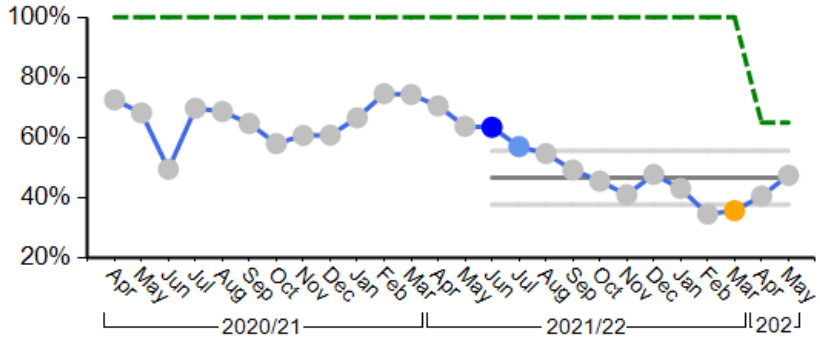
Number of Patients spending 12+ Hours in ED - Trust



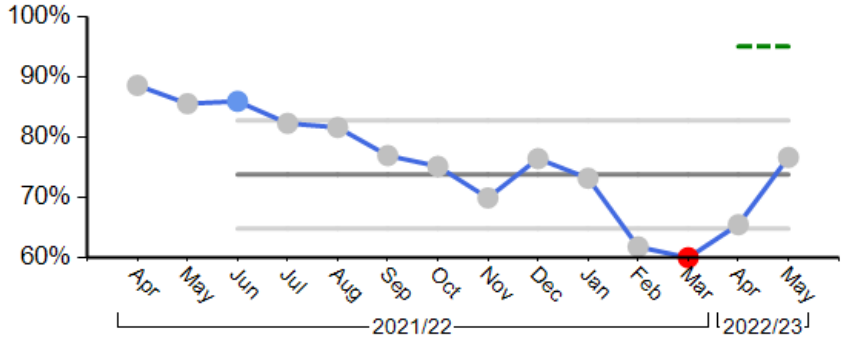
% of Patients spending 12+ Hours in ED - Trust



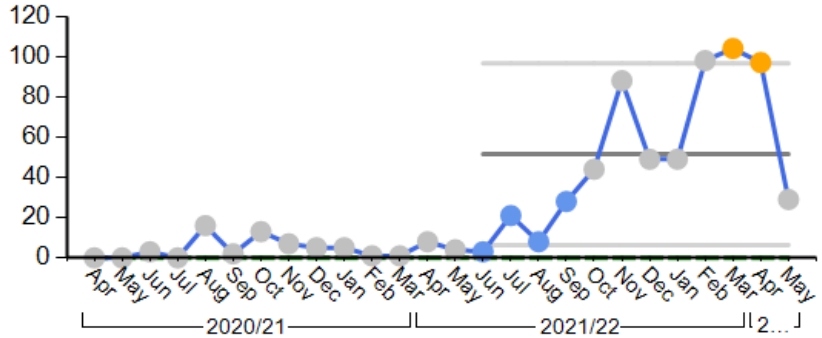
Ambulance Handovers - % within 15 Mins



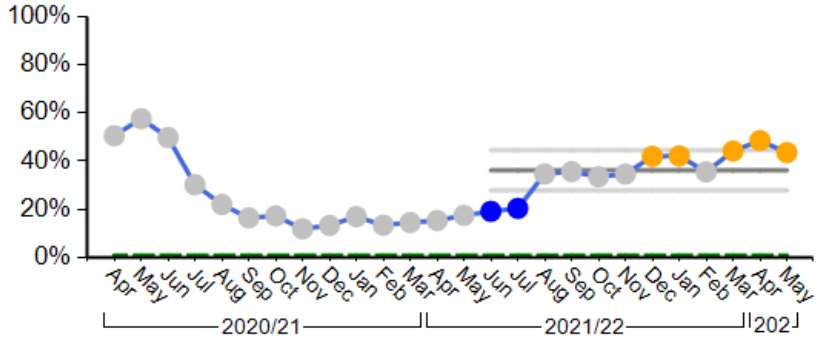
Ambulance Handovers - % within 30 Mins



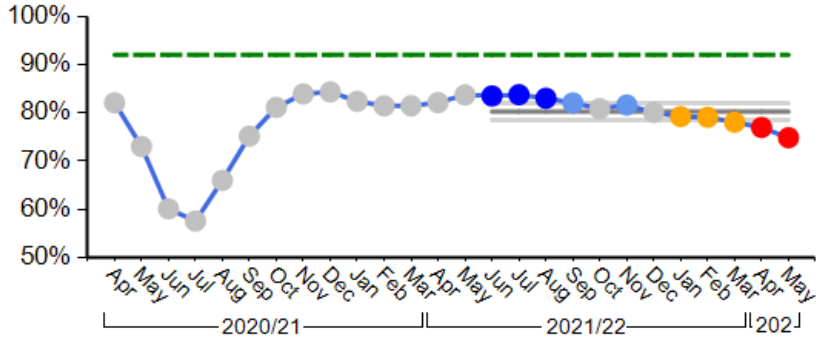
Ambulance Handover Over 60 Mins



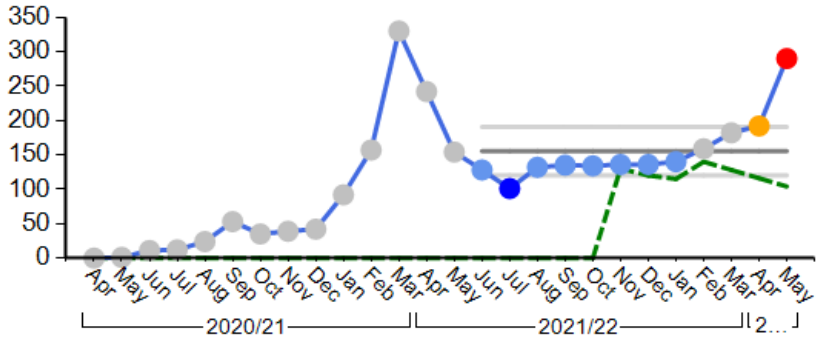
Diagnostic waits



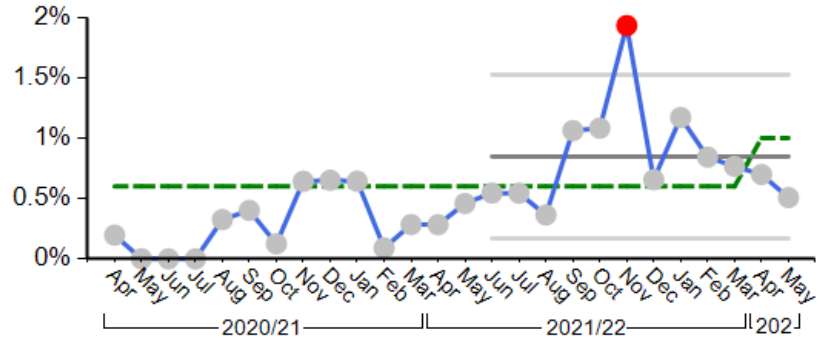
Referral to treatment: on-going



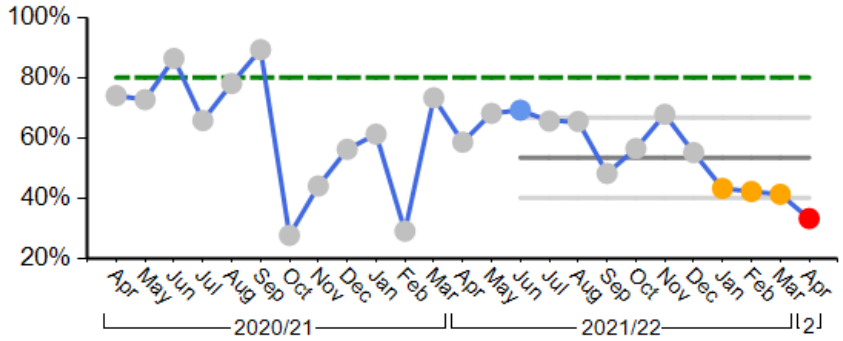
52 Week Waits



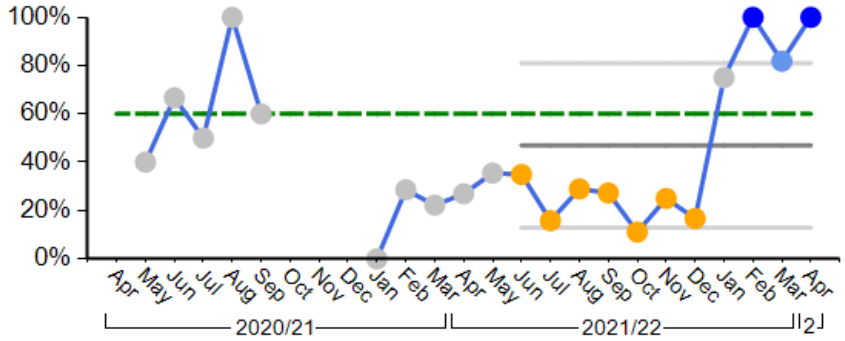
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



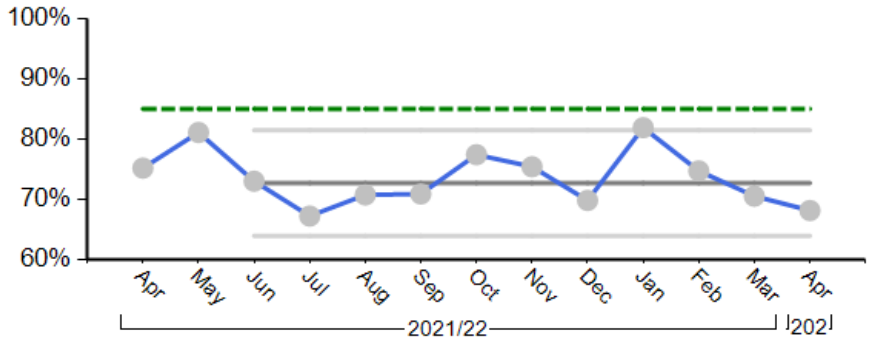
Stroke - 90% Stay on Stroke Ward



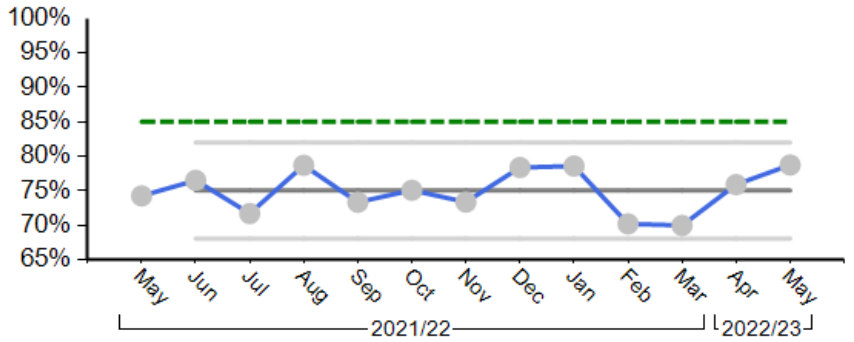
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

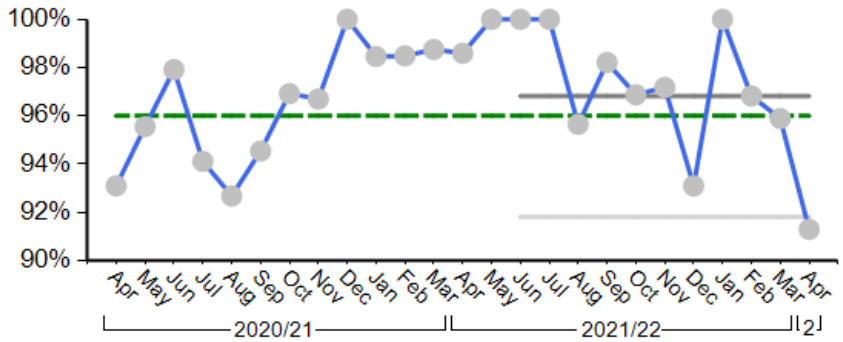
• The 62-day GP referral to treatment indicator is failing assurance and there has been a significant decline in the latest data month (April), with 22.5 breaches of the standard. Overall activity is lower than this time last year, giving us a reduced tolerance for breaches.
• The 28 Day Faster Diagnosis Standard is also failing assurance with performance in April remaining consistent with the previous month.
• Whilst not statistically significant, compliance against the 31-day treatment indicator has declined for two consecutive months, with breaches in colorectal and urology.
• Challenges remain with diagnostic capacity to accommodate the increased referrals across all modalities. This impacts both the 28 day and 62 day indicators.
• Staffing challenges within some specialties affecting the ability to deliver increased clinic capacity.
• Delays with Radiology and Histology.
• The number of patients on the Cancer PTL past day 62 continues to be of concern.

Management Action

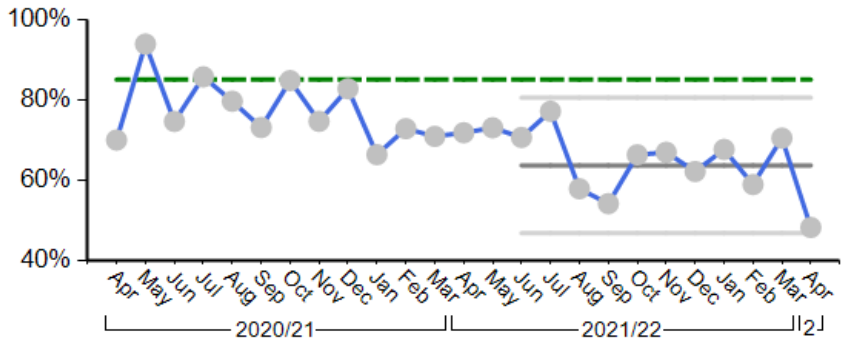
• The Trust has a Cancer Improvement Plan in place, which is managed by the Operational Teams, with support from the PMO. This plan contains tumour group level actions and mitigations.
• The patients on the PTL are monitored weekend and escalated to the directorates to action to reduce the backlog.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
31 day treatment	96%	91.3%	4	Apr 22		96%	95.9%	Mar 22	96%	91.3%	
62 day GP referral to treatment	85%	48.3%	22.5	Apr 22		85%	70.5%	Mar 22	85%	48.3%	
28 Day Faster Diagnosis Standard	75%	66%	339	Apr 22		75%	67%	Mar 22		66%	

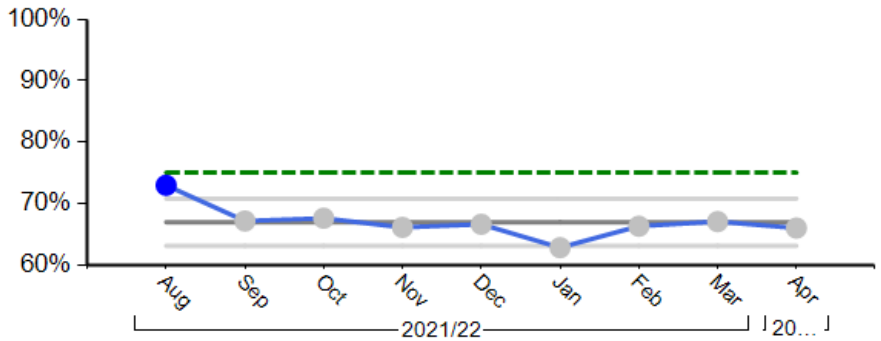
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

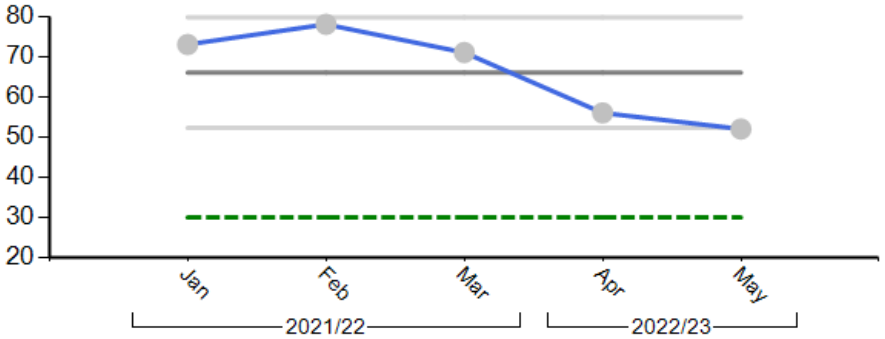
Stranded/Super-Stranded Patients/No Criteria to Reside

Issues
• Both stranded patient indicators are showing special cause concern and performance has been in excess of the target for the last 9 months. Assurance for both metrics is intermittent as the target was achieved May – August 2021.
• Following 2 consecutive months of reduction, the number of Super-Stranded patients has increased in May to the highest level for more than 2 years.
• The number of 'No Criteria to Reside' patients has reduced slightly in May.
• Impact of the bank holiday in May and increase of NEL admissions.
• Impact of coding issues.
• Indicators impacted by significant delays in 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%.

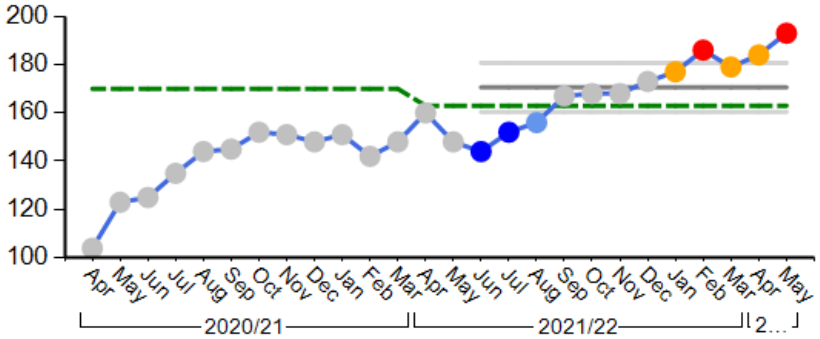
Management Action
• Focus on improvement of patients discharged by 5pm to ensure the trajectory is met including a planned campaign to commence June 2022 to ensure patients can return home before lunchtime.
• Discharge Improvement Group in place.
• Implementation of ECIST recommendations, for example the inclusion of Criteria to Reside on all Board Rounds.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
No Criteria to Reside - Avg No of Patients	30	52	52	May 22		30	56	Apr 22			
Stranded Patients (>6 Days LOS)	163	193	193	May 22	H	163	184	Apr 22	163	377	
Super Stranded Patients (>20 Days LOS)	53	71	71	May 22	H	53	60	Apr 22	53	131	

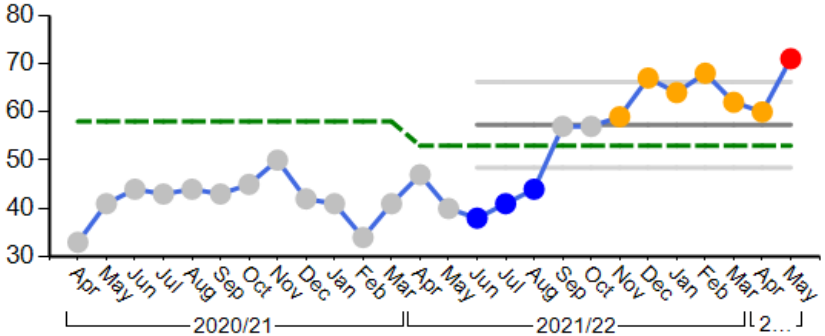
No Criteria to Reside - Avg No of Patients



Stranded Patients (>6 Days LOS)



Super Stranded Patients (>20 Days LOS)



Workforce

Organisational Development

Personal Development Reviews

An action plan has been developed and is included.

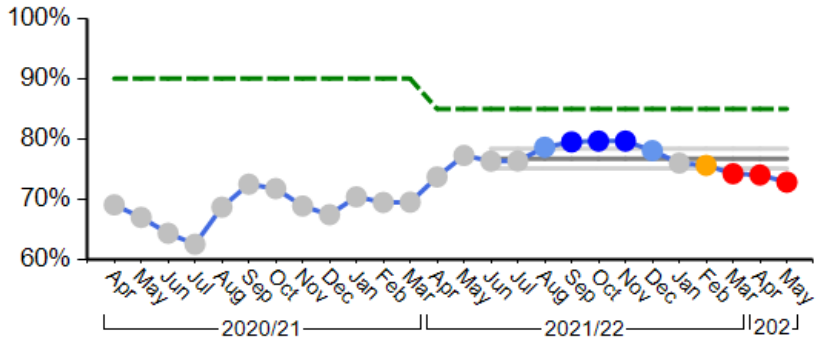
Mandatory Training

Issues
• The Mandatory Training indicator is currently assured against the 85% target. However, it is anticipated that the plan to increase to a stretch target of 90% in June 2022 will impact on assurance.
• From June 15, 2022, the Internet Explorer 11 desktop application is no longer supported on certain versions of Windows 10. There has been an issue where national ESR online applications have historically been forced to run on Internet Explorer affecting access and completion of certain mandatory training modules, which in turn, may have impacted on overall compliance.

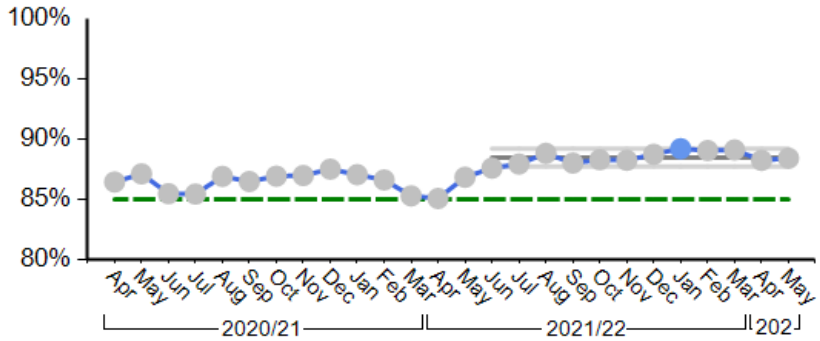
Management Action
• The Head of IT assures that the IE11 issue will be resolved by the removal of this setting from group policy. The Trust has Microsoft Edge in use across the entire estate so it should not affect staff post withdrawal of the support and any ongoing issues need to be worked through with IT Service Desk.
• The Trust has successfully maintained above the 85% target over the last 12-month period, the revised target will apply from 1st June 2022 data onwards.
• A concerted drive towards achievement of the 95% national target for Information Governance is underway.
• Targeted communications are circulated monthly to staff showing non-compliant in conflict resolution.
• Practice Educators act as mandatory training advocates driving safety & compliance within their CBU's.
• The Clinical Competency Working Group meet monthly (membership includes corporate, medical & nurse educators) whose remit it is to review, monitor and drive compliance.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	72.9%	N/A	May 22	L	85%	74.1%	Apr 22	85%	73.5%	F
Mandatory Training	85%	88.4%	N/A	May 22		85%	88.2%	Apr 22	90%	88.3%	P

Personal Development Review



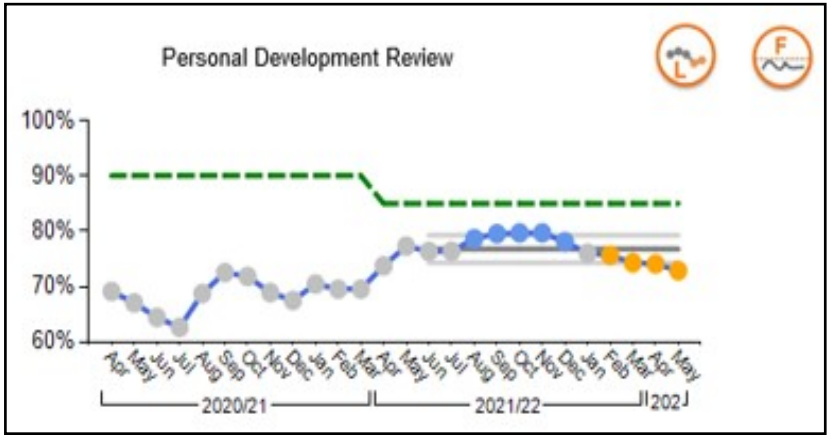
Mandatory Training



Non Medical Appraisal/Personal Development Reviews

NHS
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%	72.9%	N/A	May 22	L	85%	74.1%	Apr 22	85%	73.5%	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 overall compliance rate has been on a declining trajectory since November 2021 and in May was at 72.9%, resulting in the indicator failing assurance and showing special cause concern.

Corporate teams have the highest compliance rate but at 83.9% still fall short of the 85% target.

Capital and Estates compliance has reduced to 58%.

The three CBU's have compliance levels ranging between 70% - 76%.

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

Actions:

Monthly and weekly lists of outstanding PDRs provided to managers

PDR compliance raised at CBU SLT and Department Governance meetings

PDR compliance raised at monthly budget meetings

How to guides provided to managers in respect of recording in ESR

Previous trajectories have been formulated but not met

Corporate PDR rate was increased after direct intervention by HRD

In May HR admin targeted managers whose staff PDRs would fall out of compliance in month to ensure static position – successful in part

During June, HR admin team are targeting managers of staff who have had no PDR recorded in last three years

Escalation to SOLT for more senior direct intervention

Mitigations: Despite an increase in compliance between May and November 2021, there has been a steady decline in rates for the last six months.

The hospitals have experienced an extremely busy and fraught Winter period. All colleagues are fatigued after the last two years of activity.

Corporate teams remain best performing, in part due to the direct intervention by the HRD. Exec intervention is required to push compliance locally in their areas of responsibility.

The review of the PDR documentation and process is underway – phase 2 of the action plan.

Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• In-month sickness has decreased by 1.2% in May and is just 0.3% above target. This reduction relates to Covid sickness.
• Non-Covid sickness is showing positive variation, remaining the same as last month but 0.4% above target.

Management Action
• Focus on LTS remain in place along with triggers for persistent short-term absence.
• Appropriate referrals are in place.
• HCA absence to be highlighted in hot spot areas for discussion locally re appropriate interventions where necessary.

Vacancies

Issues
• The overall vacancy rate continues to fail its assurance measure although has marginally reduced in May.

Management Action
• Medical Vacancy rates have improved but the Trust is aware that there are a number of doctors leaving the trust to take up training posts in August, therefore it is key that we continue to work to maintain and improve our current position.
• The market for Medical posts is such that if we have any delays we will lose candidates so it is key that we move quickly through the shortlisting and interview process.
• The Trust is working to improve the HCA recruitment position with a number of interview days being held in June to bolster our numbers.
• The plan is to start the HCAs in a cohort with a strong support package in place, both in terms of training and pastoral support. The aim is to ensure that the new HCAs are well supported in their roles and are made aware of career pathways available to them. This is key given the high volume of turnover within the first twelve months of starting in post for this group and will support our retention work.
• There are a number of AHP/Therapy posts advertised as this is the key time to recruit into these staff groups as the students will shortly be qualifying. The team have gained permission to over-recruit as they are aware that once the students are in posts the market will again stagnate.

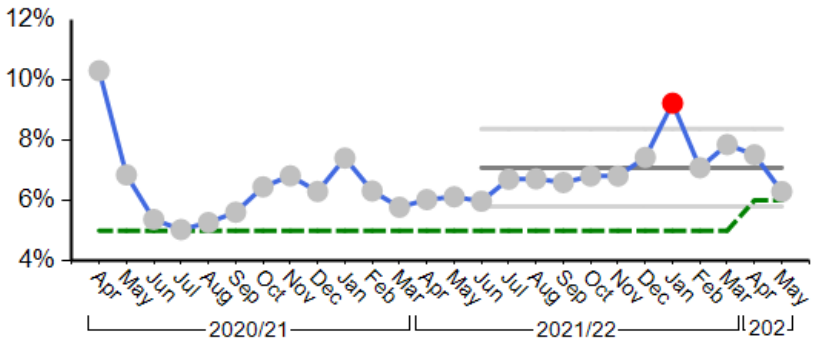
Turnover

Issues
• The in-month turnover is performing as expected.

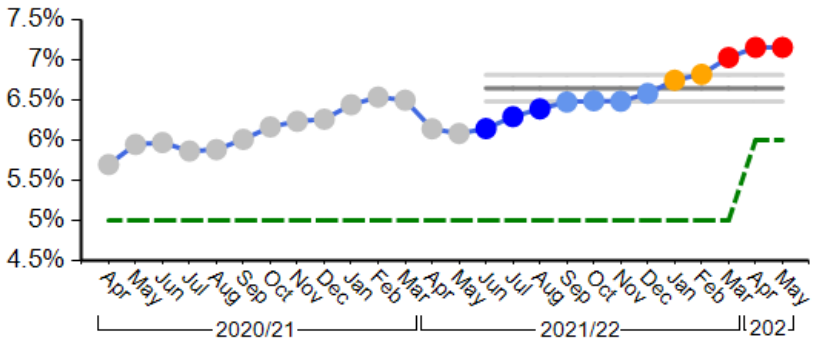
Management Action
• The Trust is developing targeted interventions, for example with the HCAs to support our aim to ensure that people want to remain within the organisation and feel well supported.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	6%	6.3%	N/A	May 22		6%	7.5%	Apr 22	6%	6.9%	
Sickness Rate (Rolling 12 Month)	6%	7.2%	N/A	May 22		6%	7.2%	Apr 22	6%	7.2%	
Sickness Rate (not related to Covid 19) - Trust	5%	5.4%	N/A	May 22		5%	5.4%	Apr 22	5%	5.4%	
Trust Vacancy Rate – All Staff	7.4%	10%	N/A	May 22		7.4%	10.2%	Apr 22	7.4%	10.1%	
Staff Turnover	0.83%	1%	N/A	May 22		0.8%	0.9%	Apr 22	9%	6.8%	

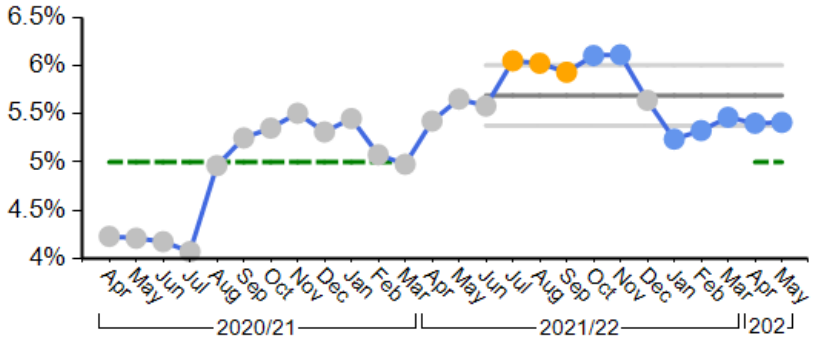
Sickness Rate



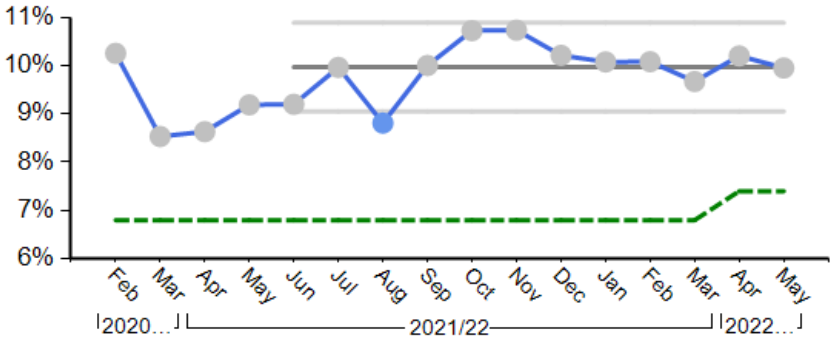
Sickness Rate (Rolling 12 Month)



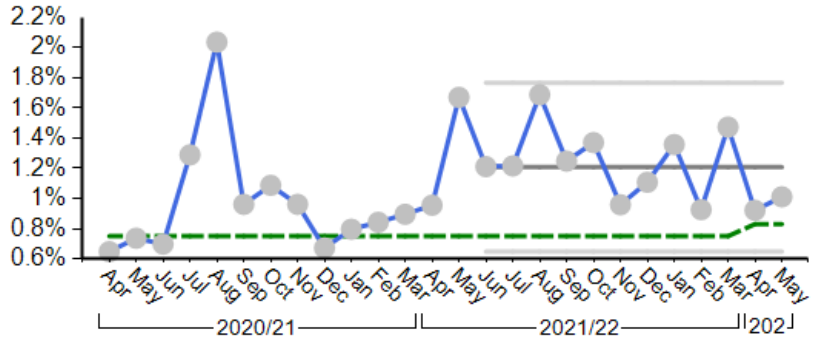
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

The Trust is reporting a £3.6m deficit at Month 2 in line with 2022/23 Plan.

The Updated 2022/23 Plan sets out a £14.1m deficit after applying:

- £5.3m ERF Income
- £10.8m CIP (3.5%), including ICS Stretch Target of £3.0m profiled into Q4
- £1.5m national funding for Excess Inflation
- £1.6m additional non-recurrent System Allocation
- £0.3m additional System Allocation for UEC pressures

Pending confirmation of ERF calculations and System performance, the Trust has assumed 100% achievement of ERF funding in M1 & M2.
ERF performance is highlighted as a risk to delivery of 2022/23 Plan in view of continued operational pressures and winter escalation experienced into 2022/23.
The Trust and ICS resubmitted Financial Plans on 20 June 2022 and awaits formal notification of acceptance from the National Team.
It has been previously highlighted that there may be an issue with accessing national sources of capital funding until an accepted 2022/23 Plan is submitted by C&M.

CIP - The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target profiled into Q4. The Trust is reporting delivery of CIP to M2.

Cash The cash balance at the end of May was £11.5m. A reduction of £1m from April's position.
Regional cash support will be required from December as the Trust is operating with a planned £14.1m deficit in 2022/23.
Trusts have been advised that the ICB will process contract payments on the 15th of each month (as opposed to 1st under existing arrangements with CCGs). As a result the Trust will require in-month support of £4.5m to cover payment runs between 1st to 15th of the month and as such repayable advances will be sought from the ICB from August.

BPPC – The Trust is currently achieving 95% against a 95% target. Note the NHS target has fallen behind and corrective action has been taken by building in an additional 2 NHS payment runs per month.

Capital - This totals £12.9m and includes agreed public dividend capital of £3.2m for fire safety, and £2.6m for Backlog.
National bids for CDC (£4.2m Community Diagnostic Centre) and TIF (£5.5m Targeted Investment Fund – endoscopy investment) are due to be submitted to NHSEI by July 2022.

	Latest				Forecast			Year to Date	
Indicator	**Plan**	**Actual**	**Period**		**Plan**	**Actual**		**Plan**	**Actual**
I&E surplus or deficit/total revenue	9.3%	9.3%	May 22		9.0%	9.0%		9.3%	9.3%
Capital Spend	£00K	£500K	May 22		£12,900K	£12,900K		£00K	£500K
Cash Balance	£10,700K	£11500K	May 22						

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Quality and Safety Committee (QSC)
MEETING DATE:	27 June 2022
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

May Alerts:

- Maternity Quarterly Update Report including an update on Ockenden (1 and 2) – challenges with compliance relating to workforce.
  Update: Formal Update due for July
  Verbal update following Maternity insight visit on 10 June with additional actions to implement changes to the emergency and elective caesarean section pathway. Report following maternity incident tabled for SOC Part 2.

- Operational Update:
  Cancer Performance and Improvement Plans –
  Update: Regional feedback of slow and steady improvement

June Alerts:

- Lack of Medical Photography provision – risk in providing evidence to support safeguarding and tissue viability teams. Executive support to be provided to secure contract.

- Overdue incident Actions – further evidence required to provide assurance of the effectiveness of the Scrutiny and Assurance Group. Update September.

- Risk to the ward refurbishment programme – with continued operational pressures, the escalation ward remains in use and therefore cannot be used as the decant ward to support completion of the programme.

ADVISE

Monthly Presentation: 'Emergency Care – How Patient Safety is Maintained'
The Committee recognised the improvements that had been made to improve patient experience and safety. It was noted that there needed to be a focus on staff morale post Covid and how staff are feeling and being supported. This also was mentioned at the Patient Experience Conference, held on 09 June 2022. It was acknowledged that this would be addressed through workforce streams including the Staff Voice Partnership that is being launched on 27 June 2022.

Patient Experience Conference
The second Patient Experience Conference was held on 09 of June 2022. The Conference included a wide range of speakers from areas across the Trust and Sefton Healthwatch and was live streamed for those who wanted to attend virtually. Within the first 24 hours of the conference taking place the YouTube link was viewed 101 times. Overall feedback from the conference was very positive with attendees commenting on the passion, honesty and compassion from those that presented.

Board Assurance Framework – Strategic Objective 1

Approved by the Committee

Integrated Governance Patient Safety Annual Report (2021/22)
Received and highlighted concern relating to overdue incident action completion (see Alert)

CQC Progress, Actions, Engagement and Quality Improvement Journey
Received by the Committee and continuation of actions within the quality priorities noted.

Integrated Performance Report
Received by the Committee. Further detail relating to Friends and family test to be reviewed within ward dashboards

Learning from Death Report Q4
Themes noted by Committee, annual report awaited and scheduled for September

ASSURE

AAA reports received from:

- Infection, Prevention and Control Assurance Group
- Quality Programme Board
- Safeguarding Assurance Group

The following Annual Reports were received:

- Safeguarding Annual Report 2021/22.
- Infection, Prevention and Control Board Assurance Framework and Annual Report 2021/22.
- Patient Experience Annual Report 2021/22.

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

Review of the Risk Register

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO129/22**	**FOI Exempt**	**NO**
Report Title	**LEARNING FROM DEATHS REPORT (QUARTER 4)**		
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 report refers to Quarter 4 (January to March 2022)

Executive Summary

To note:

- Standardised mortality rates remain consistently within tolerance.
- There was 1 avoidable death reported on the incident management system and identified via the Medical Examiner's Office and there learning points from this.
- 12 SJRs were completed during Q4.
- There report details thematic analysis.
- End of Life Care update

Recommendations

The Strategy and Operations Committee is asked to note the Learning from Deaths Report (Quarter 4).

Previously Considered By:

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

Strategic Objectives TICK RELEVANT BOX AND DELETE

- ✓ **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, Associate Medical Director for Patient Safety	Dr Kate Clark, Medical Director

Southport and Ormskirk Hospital
NHS Trust

Learning From Deaths

Quarter 4 2021-22

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

Southport and Ormskirk Hospital
NHS Trust

Contributors

Medical Examiners Office

- Dr Annie Leigh
- Dr Ciara Cruise
- Dr John Kirby
- Dr Michael Vangikar
- Dr Paddy McDonald
- Dr Sudakar Kandasamy
- Mandy Power

Compiled By

- Dr Chris Goddard

SJR Reviewers

- Dr Ann Holden
- Dr Nafe Shami
- Janette Mills
- Dr Clare Thompson

Integrated Governance

- Jess Hassan

Informatics

- Mike Lightfoot

Southport and Ormskirk Hospital
NHS Trust

Key national and local mortality indicators

	2021/22											2022/23	Target
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Rolling 12 Month HSMR	73.1	72.7	73.5	75.2	77.1	74.4	73.8	73.8					100.0
Monthly HSMR	72.3	63.9	78.1	90.9	77.9	54.3	67.2	78.3					100.0
SHMI	101.3	99.4	100.3	99.9	100.9	100.9	100.1	99.6					100.0
Local HSMR Bronchitis	10.0	9.8	10.4	18.9	29.3	30.2	20.3	18.9					100.0
Local HSMR LRTI	27.1	23.8	24.0	32.0	90.6	77.0	76.1	53.9					100.0
Local HSMR Pneumonia	79.1	75.2	78.2	80.7	82.0	78.1	74.8	71.6					100.0
Local HSMR Septicemia	77.1	76.8	75.9	76.0	78.9	79.8	78.6	80.3					100.0
Local HSMR Stroke	88.0	90.5	88.0	90.8	86.3	79.1	81.4	78.9					100.0
Local HSMR UTI	84.7	80.7	89.8	88.8	89.4	77.3	66.7	65.7	0.0				100.0
Local HSMR Acute Renal Failure	72.0	79.2	75.2	80.3	81.1	84.6	87.0	80.9					100.0
Local HSMR FNOF	38.8	41.5	46.1	47.9	50.4	54.0	56.7	51.8					100.0
Mortality Screens - %	15.49%	12.00%	13.33%	14.29%	95.95%	92.31%	92.65%	97.62%	97.33%	95.56%	97.33%	97.47%	90.00%
SJRs	2.0	1.0			3.0	1.0	3.0		7.0	3.0		5.0	0.0
2nd Review	0.0	3.0	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	72.0	50.0	75.0	77.0	74.0	52.0	68.0	84.0	75.0	90.0	75.0	79.0	77.0
In Hospital Deaths Crude Rate	23.1	18.0	26.4	21.0	24.8	18.5	22.2	31.7	30.2	35.2	28.5	30.3	31.0
LD Deaths	0.0	0.0	0.0	1.0	2.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	1.0
Sickness Absence Medics	1.74%	1.22%	1.36%	1.65%	1.91%	3.15%	1.93%	2.89%	4.84%	4.42%	4.25%	3.03%	1.00%

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

- Standardised mortality rates remain consistently within tolerance
- Crude mortality exhibiting variation which is usually expected
- Slow increase in SJRs performed

Southport and Ormskirk Hospital
NHS Trust

Avoidable deaths Quarter 4 2021-22

There was **one** avoidable death reported to the incident management system, identified via the medical examiners office.

This was the case of a lady with a single functioning kidney which had become obstructed.

There were difficulties in ensuring everyone across the Urology and Interventional Radiology departments understood the risks of delaying an outpatient nephrostomy procedure due to the patient testing positive for covid, in the context of the patient having a single functioning kidney.

There was a lack of understanding of the process and responsibilities for arranging nephrostomies at Aintree hospital during a subsequent admission when the Southport IR service is unavailable.

The obstruction led to deteriorating renal function, which then contraindicated the patients anticoagulation and the patient suffered a devastating stroke due to atrial fibrillation.

Southport and Ormskirk Hospital
NHS Trust

Avoidable deaths Quarter 4 2021-22

Learning:

Network working for specialties (such as IR) with a national shortage of consultants is a fact of modern healthcare. There is an agreement with UHA to access this, but it is never the same as being on-site. The minimum standard is to make the process known to people and as simple as possible. The harder issue is to build resilience locally.

Urology take the lead on renal obstruction. The process is being made part of urology specialty induction. The agreement with Aintree is being reviewed to make it as simple to access as possible.

Anticoagulation in worsening renal failure can be complex – discussion with haematology is advised.

Covid-19 adds risks for patients, but this does not always trump their other problems. The NHS is seeing many 'secondary harms' due to covid delays to treatment for other conditions. Each case should be considered on its individual merits – if in doubt – discuss with colleagues and always the patient. (we make better decisions together…)

Southport and Ormskirk Hospital
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SJR Quarter 4 2021-22

12 SJRs were completed in Q4

Avoidability of death rating as follows:

Definitely not avoidable: 10
Slight Evidence of avoidability: 1
Not commented on: 1

The thematic analysis of these, medical examiner scrutiny and incident reports is presented on the following slides

Southport and Ormskirk Hospital
NHS Trust

Quarter 4 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Collaboration

Best care is delivered by good clinical collaboration. Reviewing patients who have had good, collaborative care we often see documented discussions between senior colleagues in different specialties which has made decision making quicker and care more efficient.

When this happens, staff have a clear direction and confidence to act. Tests and treatments happen faster, communication is better as teams have a clear shared plan.

Good collaboration (the hallmark of which appears to be speaking to each other directly) produces better flow, due to better joint decision making and can help to reduce the safety threats of a 'blocked' hospital by making quicker decisions. It ultimately makes work easier rather than harder and reduces confrontation.

Reduced 'Chasing of referrals' leads to more time available for direct patient care.

Southport and Ormskirk Hospital
NHS Trust

Quarter 4 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Reviews also demonstrated what occurs when there is a lack of a collaborative approach. Teams with no direct discussion with each other had differing views on the escalation status of a patient, documenting differing opinions, but with no direct conversation. This led to staff confusion over how and when to escalate or palliate, confusion amongst the relatives leading to complaint and the patient dying without family present – which was the main reason for complaint.

- Escalation planning / frailty presentations / discharge / ACMP

Early consideration of escalation allows the beginning of a conversation. There is lots of evidence of this being done well and it leading to positive conversations with patients and their loved ones about their illnesses and what treatment is appropriate.

When this happens and patients die relatives tend to be better informed and prepared.

When escalation planning is vague, or patients / relatives are not informed of clinical concerns or prognosis they often feel like information was hidden or they are not being told the truth.

Southport and Ormskirk Hospital
NHS Trust

Quarter 4 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

A patient with rapidly progressive pulmonary fibrosis was not aware of the severity of his condition and consequently neither was his family. The shock of his deterioration and death led to conflict with his family.

Escalation plans and the forthcoming Treatment Escalation Proforma are an opportunity to involve patients and be open and clear about what modern medicine can and cannot achieve.

Relatives are often concerned that patients were 'not fit to be discharged' when they re-present and subsequently die. Reviewing these cases, its most frequently the case that the patient has an advanced frailty syndrome, with an acute illness (such as an infection) which has decompensated them and led to admission.

There needs to be greater focus on the 'overall' plan for the patients health, rather than 'patching up' the acute issue. Explaining frailty and its consequences is important, in some cases ACMPs can be used to be clear about what patients do and don't want as they near the end of life. Some patients may prefer to be treated at home, whilst others may wish to continue to be hospitalised periodically.

Southport and Ormskirk Hospital
NHS Trust

Quarter 4 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Weekend review

  The lack of this has been picked up as an issue in multiple reviews, however resource will not permit a review by a consultant every weekend. It is recommended that criteria be considered for who actually needs a review at a weekend by a consultant and for this criteria to be published widely.

  There was no evidence of harm caused by the lack of a weekend review.

- Visiting and access / NOK contacts

  The most frequent concern and compliment raised was around visiting. When we get this right, we have a consistent message across shifts and departments and we facilitate patients seeing their loved ones.

  The most frequent concern is lack of access, mixed messages between shifts and patients having to die alone. When this happens there is lasting damage to the bereaved.

Southport and Ormskirk Hospital
NHS Trust

Quarter 4 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Issues are periodically raised regarding next of kin contacts and how these change; but the documentation doesn't change with them. The system of recording, confirming and changing contact details for next of kin needs to be reviewed and standardised.

- End of Life Care

uDNACPR is a cross setting document, but there is increasing evidence of its lack of cross-setting and inconsistencies in the process.

It is not un-usual to find multiple uDNACPR forms scanned into Evolve for the same patient, a new one having been completed for each admission.

On one occasion when a new uDNACPR form was not completed an arrest occurred and CPR was started. This was abandoned when an old uDNACPR form (which was still in force due to a 'to continue' review date) was found.

Further development work on how this process works in practice is needed to minimise the risk of such events occurring.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO130/22**	**FOI Exempt**	**NO**
Report Title	**CQC ACTION PLAN PROGRESS REPORT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

To provide an update in relation to the Trust's Care Quality Commission (CQC) progress, actions, engagement and Quality Improvement Journey.

Executive Summary

This report provides an update in relation to the Trust's CQC progress, actions, engagement and Quality Improvement Journey.

Following our CQC inspections in 2019 and 2021, all CQC must do and should do actions have now been closed and incorporated or monitored through Clinical Audit or Quality Improvement (QI) workstreams, Quality Priorities and Strategic Objectives.

Regular reports outlining progress against the Quality Improvement Workstreams will be reported to Quality and Safety Committee throughout 2022/23 (please see Appendix A). The Quality Team is currently working with the Business Intelligence and Clinical Audit Teams to agree reporting measures.

We are currently in the process of undertaking a comprehensive well-led self-assessment across all eight well led domains using the CQC key characteristics, following initial review with St Helens & Knowsley NHS Trust colleagues in May 2022, this will be presented to Executive Committee in July 2022 and an improvement plan will be developed and shared with the Quality & Safety Committee. A well-led improvement plan will be developed and monitored through the Trust's committee structure.

Recommendations

The Strategy and Operations Committee is asked to note the CQC Action Plan Progress Report

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
✓ **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

Southport and Ormskirk Hospital NHS Trust

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Jo Simpson, Assistant Director of Quality	Lynne Barnes, Director of Nursing, Midwifery and Therapies

Southport and Ormskirk Hospital NHS Trust

Care Quality Commission (CQC) Update & Quality Improvement – June 2022

1. PURPOSE OF THE REPORT

This report provides an update in relation to our Care Quality Commission (CQC) progress, actions, engagement and our Quality Improvement Journey

2. CQC IMPROVEMENT PLAN AND ASSURANCE

Following our CQC inspections in 2019 and 2021, all CQC must do and should do actions have now been closed and incorporated or monitored through Clinical Audit or Quality Improvement (QI) workstreams, Quality Priorities and Strategic Objectives.

A 'Check and Challenge' process is in place to ensure that actions where we have closed the improvements remain embedded and sustained, this includes Quality and Safety Walkabouts, SOCAAS (Southport & Ormskirk Clinical Assessment and Accreditation Scheme), Ward Dashboards and use of the Tendable audit programme.

Our Quality Priorities agreed for 2022/23 include:

- Reduction in Falls
- Reduction in pressure Ulcers
- Acute Kidney Injury, Nutrition & Hydration
- Improve communications with families prior to Discharge or End of Life
- Compliance with the immediate and essential actions of the Ockenden 2 Enquiry

Improvement workstreams for 2022/23 include:

- Safer Discharges
- DNACPR / Capacity Assessments
- Deteriorating Patient
- Medicines Safety
- Improving Safety Culture
- End of Life Care
- Safe Staffing (Nursing & Medics)
- Privacy & Dignity
- Mandatory Training
- Patient Experience
- Well Led

Regular reports outlining progress against the Quality Improvement Workstreams will be reported to Quality and Safety Committee throughout 2022/23 (please see Appendix A). the Quality Team is currently working with the Business Intelligence and Clinical Audit Teams to agree reporting measures.

3. CQC PREPARATION

Under the CQC's new monitoring framework there is a move away from the reliance on comprehensive onsite inspections as the trigger for assessing quality and issuing ratings. Instead, there is more reliance on a risk assessment and good quality data from a variety of sources, including service users' feedback, combined with focused onsite inspections where necessary, to assess quality and change a rating.

Through this new framework the Trust successfully completed two CQC 'core services' monitoring templates in 2021 for Maternity and Medicine core services. Following submission, the CQC were satisfied with evidence submitted and requested no further information or action.

We are also in the process of developing a CQC readiness programme, working with the CBUs to self-assess against the CQC Key Lines of Enquiry (KLOE) for Core Services. We are also developing templates for core service reviews including peer reviews with support from St Helens and Knowsley NHS Hospital Trust (STHK) and Stakeholders.

4. CQC ENGAGEMENT

We also continue to meet with CQC colleagues bi-monthly with a joint agenda to discuss any areas of focus and enquiries. The engagement meetings provide an opportunity to resolve any enquiries in a timely manner. Our next engagement meeting is to be held on 04 July 2022. The focus of our next meeting will be Covid-19 and recovery plan, A&E quality and performance and the new Governance structure for the Trust following the partnership arrangements with St Helen's and Knowsley NHS Trust.

5. CQC WELL LED SELF-ASSESSMENT PROGRESS

To support our Well Led improvement journey, the Trust also in the process of undertaking a comprehensive Well-Led self-assessment across all eight well led domains using the CQC key characteristics. Executive colleagues have completed a self-assessment template, this has been reviewed in conjunction with STHK colleagues, this will be presented to Executive Committee in July 2022 and an improvement plan will be developed and shared with the Quality & Safety Committee.

6. CONCLUSION & NEXT STEPS

Whilst progress has been made, there is a need to focus on specific key areas including

- Ensuring that actions we have closed the improvements remain embedded and sustained
- Developing a readiness programme for any future CQC inspections, including self-assessments and core service reviews.
- Continue Quality and Safety Walkabouts, SOCAAS (Southport & Ormskirk Clinical Assessment and Accreditation Scheme), use of the Tendable audit programme

7. RECOMMENDATIONS

The Strategic & Operations Committee is asked to receive the update in relation to the CQC progress, actions, engagement and well-led improvement journey.

Southport and Ormskirk Hospital
NHS Trust

Appendix A

CQC Recommendations

CQC Themes for Improvement (Must Do's)	Update on Actions	
Privacy & Dignity	• SOCAAs assessments, Tendable monthly clinical standards audits undertaken Weekly Quality & Safety Walk arounds in place. Outcomes reviewed at ward meetings	
DNACPR / Capacity Assessments	• QI workstream in place • Trust Wide DNACPR audit completed biannually. Treatment Escalation Plan (TEP) in place • Progress monitored via Resus Committee	
Medicines Management	• Appropriate governance structure in place • Suite of metrics reported through PIDA and Medicines Safety Committee	• Audits in place through Tendable App • My Kit Check rolled out to monitor fridge & room temperature
Safe Staffing (Nursing & Medics)	**Nursing** • Successful International Nurse Recruitment Programme • Significant improvement in fill rate (93.4%) • Reported in IPR	**Medics** • Fragile Services workstream in place / Partnership with StHK • Medical vacancies are now at the lowest level the Trust has seen for at least 4 years, with the vacancy rate which is currently at 5.8%
Mandatory Training	• Appropriate governance in place • Monthly report by subject in place	• Targeted support to enable staff to attend training • Monitoring of essential skills training
Safe Discharges	• Discharge Improvement Programme in place with 5 workstreams • Monitoring of Complaints and e-mail address for Discharges (reduction since 2021/22 • Incorporated into Quality Priority & Strategic Objective for 2022/23	
Nutrition & Hydration	• Monitored through Ward Dash Board • Nutrition, Hydration & AKI is a Quality Priority & Strategic Objective for 2022/23 • Targeted support for wards by Quality Matrons – significant improvement MUST assessments for admissions ward	
Well Led	• New Vision in place • Corporate Objectives agreed	• Well Led Self Assessment • Progress updating policies

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO131/22**	**FOI Exempt**	**NO**
Report Title	**INFECTION PREVENTION AND CONTROL ANNUAL REPORT**		
Executive Lead	Kate Clark, Medical Director		
Lead Officer	Andrew Chalmers, Consultant Nurse/ Deputy Director – Infection Prevention and Control		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Trust's performance in relation to Infection Prevention and Control (IPC) in 2021/22.

Executive Summary

This document reports on the 2021/22 annual IPC programme and includes the actions taken to ensure that the Trust meets the requirements of NHS England/Improvement and the Care Quality Commission. It also includes an update against the current IPC BAF (Board Assurance Framework).

The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- The National Standards of Healthcare Cleanliness 2021
- Antimicrobial Stewardship: "Start Smart – Then focus" 2011 (updated March 2015)
- NHS England IPC BAF December 2021

The Hygiene Code is underpinned by ten compliance criteria which this year's programme of work is mapped to; this will ensure that the Trust continues to maintain and strengthen its compliance.

<u>Progress</u>

Highlights which confirm continued progress in IPC Measures include:

- Of the 40 identified actions in 2021/22 only two have remained Amber (IPC annual mandatory training & IPC Link Worker meetings)
- C.Diff numbers increased in 2021/22 and the Trust objective as given by NHSE/I was exceeded; however this was the case in surrounding trusts. The application of the C.Diff action plan started to take effect following the October peak wherein the monthly figures dropped so as not to exceed the monthly trajectory
- E coli bacteraemia total was 57 which was impressively below the NHSE/I objective of 70
- Slight increase in MSSA , however within two standard deviations of the Northwest average, no overt lapses in care, infection sources often related to chronic conditions with three cases related to community Covid-19 infections
- Blood culture contamination rate has dropped slightly for a second year an average of 5.5% in 2020/21 to 5% in 2021/22 – the Practice Educators with the IPC team continue on strategies to reduce this further
- CPE testing of patients from high-risk groups continues to occur resulting in identification of one possible hospital case, the other three cases were identified on admission and were isolated
- Covid-19 positive patients totalled 1700 with 136 possible hospital acquired; similar rates across Northwest hospitals as reported in NW IPC NHSE/I monthly meetings – many

innovative methods employed to maximise patient safety ranging from processes such as isolation and testing to equipment and the environment e.g. air purifiers and CO2 monitors

Areas requiring further improvement

- Reducing gram negative bacteria blood stream infections – catheter care review, antibiotic stewardship
- Improving IPC Level 2 Mandatory Training
- Re-energising the IPC Link Workers – conduct audits and experts in basic IPC standards
- Hard Facilities Management, Deputy COO & IPC collaboration in new builds and remodels at design stage and consider ways to improve ventilation
- Continued focus on C.Diff reduction through engagement, education and antimicrobial stewardship
- Practice Educators, IPC team and Microbiology Clinical Scientist continue on strategies to reduce blood contamination rates further
- Improve cannula care through review of devices and improved training and documentation

Recommendations

The Strategy and Operations Committee is asked to receive and note the 2021/22 Infection Prevention and Control Annual Report.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **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:**
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Southport and Ormskirk Hospital NHS Trust
2021/22 Infection Prevention and Control (IPC) Annual Report

Executive summary

This document reports on the 2021/22 annual IPC programme and includes the actions taken to ensure that the Trust meets the requirements of NHS England/Improvement and the Care Quality Commission. It also includes an update against the current IPC BAF (Board Assurance Framework).

The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code,
- The National Standards of Healthcare Cleanliness 2021
- Antimicrobial Stewardship: "Start Smart – Then focus" 2011 (updated March 2015)
- NHS England IPC BAF December 2021

The Hygiene Code is underpinned by ten compliance criteria which this year's programme of work is mapped to; this will ensure that the Trust continues to maintain and strengthen its compliance.

Highlights which confirm continued progress in IPC Measures include:

- Of the 40 identified actions in 2021/22 only 2 have remained Amber (IPC annual mandatory training & IPC Link Worker meetings)
- C diff numbers increased in 2021/22 and the Trust objective as given by NHSE/I was exceeded, however this was the case in surrounding trusts. The application of the C diff action plan started to take effect following the October peak wherein the monthly figures dropped so as not to exceed the monthly trajectory
- E coli bacteraemia total was 57 which was impressively below the NHSE/I objective of 70
- Slight increase in MSSA , however within 2 standard deviations of the NW average, no overt lapses in care, infection sources often related to chronic conditions with 3 cases related to community COVID infections
- Blood culture contamination rate has dropped slightly for a 2nd year an average of 5.5% in 2020/21 to 5% in 2021/22 – the Practice Educators with the IPC team continue on strategies to reduce this further
- CPE testing of patients from high-risk groups continues to occur resulting in identification of 1 possible hospital case, the other 3 cases were identified on admission and were isolated
- COVID positive patients totalled 1700 with 136 possible hospital acquired; similar rates across NW hospitals as reported in NW IPC NHSE/I monthly meetings – many innovative methods employed to maximise patient safety ranging from processes such as isolation and testing to equipment and the environment e.g. air purifiers and CO2 monitors

Monitoring delivery of the program

Progress against the programme was monitored by the Infection Prevention and Control Assurance Group.

Abbreviations used in the document

AAA	Alert, Advise, Assure
ADON	Associate Director of Nursing & Allied Health
ADO	Associate Director of Operations
AMD	Associate Medical Director
BAF	Board Assurance Framework
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CO2	Carbon Dioxide
COO	Chief Operating Officer
CPE	Carbapenemase Producing Enterobacteriaceae
DIPC	Director of Infection Prevention and Control
DONQ	Director of Nursing and Quality
FM	Facilities Management
FOI	Freedom of Information
GNB	Gram Negative Bacteria
HAIR	Healthcare-associated infection Review
HCAI	Healthcare-associated Infection
HEAT	Hygienic Environment Action Team
ICS	Integrated Care System
IPC	Infection Prevention & Control
IPCAG	Infection Prevention and Control Assurance Group
IPCT	Infection Prevention and Control Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PPE	Personal Protective Equipment
PICC	Peripherally-inserted central catheter
PIR	Post Infection Review
RCA	Root Cause Analysis
SIRG	Serious Incident Review Group
SSI	Surgical Site Infection
UKHSA	United Kingdom Health Security Agency
WSG	Water Safety Group

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
1. Systems in place to manage and monitor the prevention and control of infection							
Hold four IPCAG meetings, the minutes of which are submitted to the Quality and Safety Committee with monitored attendance The IPCAG will receive from the IPCT, CBUs and groups reporting to the IPCAG quarterly information on: ○ HCAI performance ○ Audits & surveillance ○ Progress on action plans ○ Outbreaks & Incidents ○ New publication relating to IPC/Microbiology	DIPC	Quarterly	Green	Green	Green	Green	IPCAG meetings were held in April, June, August, October 2021 and March 2022; minutes were submitted to the Quality & Safety Committee.
Attendance at and provision of quarterly reports to the Quality and Safety Committee	DIPC	Quarterly	Green	Green	Green	Green	The DIPC attends Quality & Safety committee and reports the monthly update from the monthly IPC performance report and provides the AAA report from the IPCAG
Present the 2022/23 annual programme to the Trust Quality and Safety Committee	DIPC	Annually	Green				The Trust 2020/21 programme was submitted to the 28/6/21 meeting and the 2022/23 programme will be submitted to the June 2022 meeting
Collate and submit mandatory surveillance data as directed by NHS England onto the UKHSA data capture system	IPCT	Monthly	Green	Green	Green	Green	Monthly surveillance data submitted by the IPC team and approved by the DIPC. Data also provided to the CCGs and is widely distributed to Trust Managers and Directors

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Pharmacy teams to undertake quarterly antimicrobial audits with the support of a Microbiology Consultant and the antimicrobial pharmacist	Antimicrobial Pharmacist	Quarterly	Green	Green	Red	Green	Antimicrobial audit completed 1st and 2nd quarters – reported in IPCAG meeting. 3rd quarter report not completed due to staffing pressures in pharmacy and temporary antimicrobial pharmacist required to work on the wards. Quarter 4 audit completed and compiled for presenting to the Antimicrobial Stewardship Meeting and to IPCAG.
Clinical teams within CBUs in collaboration with the Risk and IPC teams to lead on the RCA of each case of hospital apportioned *C difficile*, MRSA bacteraemia, device related bacteraemia and gram negative bacteraemia (GNB) to establish the root cause and identify any lessons learnt	DIPC	Weekly reviews	Green	Green	Green	Green	RCA processes have been followed so that the Trust is current within 4 weeks of any C diff or MRSA case. Historical IPC reviews of hospital acquired COVID cases have also been completed and more recent cases are being reviewed to ensure that these have also been completed. GNB RCAs are completed by the IPC team in collaboration with the patient's medical and nursing staff. Lessons learned are communicated through CBU governance and IPC operational group meetings as well as in ward/department safety huddles and medical training sessions.
IPC Team will maintain professional competence by undertaking relevant training and attendance at IPS/HIS Conference for Professional updating	IPCT	Annually	Green	Green	Green	Green	The newly recruited IPC specialist nurse is enrolled at Manchester University to receive the appropriate IPC education required for their post. The remaining IPC nurses have participated in education/training through webinars, professional journals and professional groups, but haven't attended National conferences due to their limited availability during the COVID pandemic. In 2022/23 national conferences are once more being held therefore there is greater access for attendance; the IPC Matron is enrolled in a leadership course.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections							

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Facilitation of IPC inspections within clinical settings with reports to the IPCAG	IPCT	Monthly	Green	Green	Green	Green	IPC inspections have continued throughout the year across CBUs led by the IPC team. In the 1st half of the year CBU Matrons were invited to attend for their respective areas, in the 2nd half the inspection team was bolstered by Estates and Facilities representatives. The Trust average compliance across the CBUs was 85.9%.
IPC Team support and attendance at Water Safety Group (WSG) meetings	IPCT	Quarterly	Green	Green	Green	Green	WSG meetings held June, September, and October 2021, and January and March 2022. Trust has commissioned a new water authorised engineer and also provided water safety training to key personnel. Water flushing processes have been reviewed and updated as has the water safety action plan.
IPC Team support and attend the Decontamination Assurance Group Meeting	IPCT	Quarterly	Green	Green	Green	Green	The Decontamination group met in June, October and December in 2021 and in February 2022. The ADO for Planned care has chaired the meeting except for when unavailable at which time the Deputy DIPC has chaired it. In addition to the IPC team (including Deputy DIPC and Consultant Microbiologist) the group includes the Authorised Engineer for Decontamination, the Trust Decontamination Manager and representatives from other Trust departments with a vested interest in decontamination, e.g. Theatre Matron, Endoscopy Manager, Estates Manager and Finance representative.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Provide expert advice to all service developments to ensure infection risks are considered, in particular in the built environment from planning stage to commissioning	IPCT	Ad hoc	Green	Green	Green	Green	Throughout the year the IPCT has provided advice and some instances instigated Estates projects. Some of these projects include: upgrade of treatment centre and endoscopy at ODGH, Ward 1 upgrade to facilitate a COVID isolation area, NWRSCIC plans/negotiations to provide additional isolation rooms and wheelchair decontamination area, installation of air purifiers and CO2 monitors, ward refurbishment completion on wards (11B, 11A, 7B and 10A), internal and external waste storage facilities, theatres 4 & 5 at Southport site ventilation/cooling upgrade.
Review of cleaning products and practices in line with national guidelines and scientific evidence	IPCT	Ad hoc	Green	Green	Green	Green	Continued to work with Soft FM with respect to cleaning standards and products. Soft FM managers are part of bronze and silver command structures, as well as represented on IPC Operational and Assurance groups. The IPC team works with domestic supervisors and nursing staff to ensure side rooms have the appropriate cleans based on infections. Chlorine dioxide disinfectant remains the mainstay for hospital cleaning with adjuncts of UVC light and hydrogen peroxide vapour disinfection.
3. Provide suitable accurate information on infections to the patient, public and other service providers							
Work with PALs, Complaints, Risk and Communication teams to provide timely and accurate information to press enquiries, FOI requests, patient concerns and complaints	IPCT	As required	Green	Green	Green	Green	The IPC team continues to work with hospital departments to answer complaints and FOI queries as these pertain to IPC. In addition, work closely with the Comms team to provide information to the public, interact directly with patients and patients relatives that voice concerns and have assisted the risk department and the Trust Solicitor with complaints.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Patient information leaflets to be available on the Trust website	Comms Team IPCT	As required	Green	Green	Green	Green	Patient leaflets available on MRSA, C diff, Norovirus and Influenza. Information on IPC practices and hand hygiene also available in patient admission booklets. Also utilise NHS and UKHSA leaflets on CPE, VRE and food borne illnesses. During the coronavirus pandemic information leaflets have continued to be provided and updated for patients including advice on COVID screening and isolation with input from the Clinical Reference Group.
Provide IPC data to CBUs for local information boards for clinical areas	IPCT	Monthly	Green	Green	Green	Green	Monthly IPC Performance and quality reports distributed across the Trust and reported in Trust command structures as well as IPC operational and assurance groups which are attended by CBU senic personnel.
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion							
Continue inserting information stickers for C diff in the health records of patients and provide relevant patient information leaflets	IPCT	As required	Green	Green	Green	Green	Every in-patient who has a community or hospital acquired C diff infection is noted in the patient's notes and an information leaflet is provided to each affected patient
Flagging on patient administration system (Medway) of C diff, MRSA, CPE, VRE or other significant organisms that have an infection risk for appropriate management on readmissions	IPCT	As required	Green	Green	Green	Green	Every patient who is colonised or infected with MRSA, C diff, CPE, VRE or other significant multidrug resistant organism is alerted on Medway so that clinicians are alerted on subsequent admissions so that the appropriate precautions can be taken.

Actions required	Lead	Due Date	Q1	Q2	Q3	Q4	Progress update
Raise awareness on current IPC issues within the Trust; - Monthly Performance Reports - Themed articles published in Trust News - Tabletop training and ward visits - Ad-hoc drop-in training sessions as required when new situations arise	IPCT	Monthly As required	Green	Green	Green	Green	The IPC team identifies issues and learning points from monitoring, surveillance, inspections, RCAs, PIRs, incidents and outbreaks and incorporates these into the monthly performance report. During the COVID pandemic the IPC team in conjunction with Gold and Silver Command have provided news bulletins, posters, handouts, frequent ward and department visits to train, support and inform. The IPC team have held a number of tabletop awareness sessions promoting IPC and hand hygiene and also produced a C diff learning pack that has been used on wards where there has been C diff cases. Other training sessions on wards have included equipment cleaning and processes. The DIPC and the Deputy DIPC have also presented on Team Brief Live on a number of occasions.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to others							
Results of correct isolation on admission (MRSA) and isolation of diarrhoea until after specimen result is known, published in monthly performance report	IPCT	Monthly	Green	Green	Green	Green	The IPC nurses have daily (7 days per week) contact with the wards as well as with the Bed Management team and identify patients requiring isolation. The Trust epidemiology system (ICNET) also identifies new admissions with MRSA history or new cases of MRSA which the IPC team responds to by arranging isolation with the ward and Clinical Coordinator (bed manager), there have been instances during the COVID pandemic that not all cases of MRSA have been isolated due to lack of immediate side rooms, however the IPC team liaises with the clinical teams and risk assesses who is in greatest need of isolation and will also assess the suitability of Redirooms (temporary isolation pods that can be set up within a patient bay).
All patients screened positive for MRSA and previously known to be MRSA positive to be prescribed suppression therapy. IPCT audit compliance with MRSA Pathway	IPCT	Monthly	Green	Green	Green	Green	The IPC team provides a monthly report to CBUs on compliance of the MRSA pathway. The IPC team has continued to provide care plans and insert MRSA stickers into case notes of patients identified as MRSA positive – this has led to a significant increase in the appropriate prescribing of MRSA suppression treatment as well as improved the use of MRSA pathways.
Action plans for results of MRSA Pathway Audits presented at IPCAG	HON	Quarterly	Green	Green	Green	Green	Primarily an issue found in MEC CBU and actions have been reported in quarters 1 and 2 which have been ongoing. Most recent audits have reported good compliance with pathways being available in the majority of cases however, there still is an issue on some wards with how fully these pathways are completed, hence further review needed to either simplify the pathway or to improve training.

IPC Team to facilitate comprehensive surveillance system for HCAI with monthly reporting	IPCT	Monthly	Green	Green	Green	Green	The IPC team facilitates HCAI surveillance and reports to UKHSA and the CCG, in addition to identifying issues and instigating actions to provide resolutions. During the COVID pandemic the Trust has been required to report also to NHSE/I which has been a collaborative action by both the IPCT and Business Intelligence.

Maintain close links with relevant agencies (UKHSA, NHSE/I, CCGs and providers of Community IPC Services) to ensure that robust communication channels are maintained	IPCT	As required	Green	Green	Green	Green	The IPC team maintains close links with local agencies with frequent communications through telephone, e-mails and MS Teams meetings. The CCG Quality manager attends the Trust weekly IPC Bronze meetings and the IPC team attends the monthly NW IPC meetings.
6. Ensure all staff are fully involved in the process of preventing and controlling infection							
A requirement to comply with infection prevention and control is included in all job descriptions: Zero tolerance to non-compliance with IPC practices to be monitored and following procedure introduced; 1st observation - File note and discussion with line manager 2nd observation - Interview with higher manager/director 3rd observation - Disciplinary process commenced	Human Resources Matrons Consultants EMD DON IPCT	As required	Green	Green	Green	Green	The IPC nurses have identified issues regarding hand hygiene, PPE and cleaning and in some circumstances employee managers have needed to intercede when staff have repeatedly been non-compliant with aspects of IPC, however on the whole it has been our experience that staff have been responsive to reminders and instructions and the majority of incidents haven't needed to be escalated.
Clinical and Nursing staff attend RCA meetings to ensure robust process	Matrons AMDs	As required	Green	Green	Green	Green	RCAs for Planned Care and Medicine and Emergency Care CBUs have set meetings in the week. Specialist Services CBU RCA meetings are set as required. There are structured meetings with clinical teams with respect to C diff and MRSA. Other RCAs are completed at ward level with clinicians and IPC team in collaboration with the Microbiologist and the Deputy DIPC

Local and personal IPC Performance is discussed at staff appraisal	All Managers	As required	Green	Green	Green	Green	IPC is part of staff appraisals who work in a clinical setting and includes a review of staff IPC and hand hygiene training. Dependent on the job role staff are also required to complete antimicrobial and ANTT training which is reviewed as part of their appraisals.
7. Provide or secure adequate isolation facilities							
IPCT and Clinical Coordinators/Bed Managers maintain the isolation information spreadsheet on the Trust Intranet to ensure that availability of isolation facilities is readily available	IPCT Clinical Coordinators	Daily	Green	Green	Green	Green	The IPC team provide a 7 day per week service and update the isolation room spreadsheet throughout the working day. The team meet with the clinical coordinators/bed managers and discharge planning team 3 times a day or more frequently as required to cross reference information and provide updates and give feedback. During the COVID Pandemic the Trust BI team produced a COVID interactive dashboard which has continued to be used as an adjunct to the isolation room spreadsheet.

IPCT provide advice and support on the management of infectious patients during an increased incidence of infection or outbreak to contribute to the management and appropriate usage of the side rooms	IPCT	As required	Green	Green	Green	Green	The IPC team is continually gathering syndromic and laboratory intelligence with respect to potential incidences and outbreaks and initiates investigations and incidence/outbreak meetings as required. In the 1st quarter no outbreaks reported, in the 2nd quarter there were COVID outbreaks on wards FESS, 11A and SSU, at the end of the 3rd quarter as COVID was once more increasing in the community there were outbreaks on wards SSU, G and 11B, and in the 4th quarter COVID outbreaks on FESS, 7B, 14A, 14B, SIU and ward 1. Some of these outbreaks affected single patient bays while others affected more than 2 patient bays. In the 4th quarter there was a very minor outbreak of norovirus on ward 15B that was quickly resolved and affected a minimal number of patients, at the same time on 14A there was an outbreak of norovirus – this resulted in the ward being closed to admissions for several days until patients were no longer symptomatic and all the rooms deep cleaned and disinfected. The IPC team during the year had bronze IPC meetings that ranged from daily to once a week dependent on the escalation level. These meeting included senior managers and directors, as well as the IPC team and the CCG Quality Manager. Outbreaks were reported to UKHSA and NHSE/I. The majority of the COVID outbreaks occurred due to contact with asymptomatic patients that tested negative on admission then tested positive on either day 3 or 5 post admission, some patients may have acquired their infections from visiting relatives.

Patients identified with Type 5-7 stools (as defined by the Bristol stool Chart) are isolated within 2 hours	Nurse in charge of Ward Clinical Coordinators	As required	Green	Green	Green	Green	Patients that are symptomatic with diarrhoea on admission are isolated on admission. There are some patients that develop diarrhoea post admission which have experienced delays to isolate, however these delays are typically due to bed capacity issues, or there has been a clinical decision based on the patient's condition, treatment or test results that the cause of the diarrhoea was non-infectious and therefore isolation not required e.g. recent aperients, constipation with overflow

8. Secure adequate access to laboratory support as appropriate							
Laboratory standard operating policies and procedures meet Clinical Pathology Accreditation standards	Lab Manager Contract Monitor	As required	Green	Green	Green	Green	The laboratory meets the required standards as evidenced by routine inspections by regulatory body.
Issues with respect to provision of laboratory service to be monitored by the Trust Contract Monitor so as to ensure the provision of an adequate level of service that will ensure that Trust IPC needs are met	DIPC IPCT Contract Monitor	As required	Green	Green	Green	Green	The laboratory contract is monitored by the Trust Contract Monitor and the IPC Consultant Nurse maintains close contact with the laboratory managers
9. Have and adhere to policies and protocols for the prevention and control of HCAI							
IPC policies include the IPC Policy, Isolation Policy, Management of Gastroenteritis, Influenza Policy, and Hand Hygiene Policy, there is also a recent Coronavirus policy and these are backed up by the Infection Prevention and Control Manual which provides guidance on all other aspects of Infection prevention and Control	IPCT	As required	Green	Green	Green	Green	During the COVID pandemic there have been numerous reiterations of national guidance with respect to IPC, hence hospitals followed these protocols through a command-and-control structure and completing the IPC BAF, irrespective of this IPC team and link works has continued to audit against the Trust policies and the national guidance which are reported in the monthly IPC performance/quality reports. As the end of this year finishes and the command-and-control structure from the centre diminishes the Trust IPC policies now require updating to take into account any new guidance including the reported imminent release of the national IPC manual.
Compliance with the Hand Hygiene Policy is audited each month and results are published in the monthly performance reports	Link Workers IPCT	Monthly	Green	Green	Green	Green	Hand hygiene audits are undertaken monthly by the IPC link workers and ad hoc audits by the IPC team. The average compliance for the year is 96% with on average 83% of clinical areas being audited per month throughout the year.

IPCT Annual Audit Programme	IPC Team	Monthly	Green	Green	Green	Green	The IPCT audits are completed monthly and reported on the IPC Monthly Performance and Trust Quality reports. The Trust utilises the audit package Perfect Ward (name now changed to Tendable) which has an IPC section – at the end of March 2022 the IPC team have updated the IPC section with new questions and are reviewing the audit process. IPC ward audits have been conducted throughout the year with IPC nurses and ward Matrons – towards the end of the year following on from discussions with Hard and Soft FM it has been decided to include Managers from these departments as many of the issues identified during these audits come under these departments. The IPC audit average score across the Trust for 2021/22 was 85.9%.
10. Ensure so far as is reasonably practicable that healthcare workers are free of and are protected from exposure to infections during the course of their work, and that all staff are suitably educated in the prevention and control of infection							
All staff must attend IPC training at induction; following induction clinical staff and non-clinical staff who work in a clinical environment are required to have annual updates. Attendance is monitored at the CBU and Trust Quality and Safety meetings	Assistant Directors of Operations	Yearly	Amber	Amber	Amber	Amber	IPC level 1 training continues to be high with most months hitting 94% and never dropping below 92%. Level 2 training has improved from last year's monthly average of 75% to 82% this year, the months of December and January at 84% very nearly met the Trust target of 85%. Training is now offered online which has improved accessibility for many staff especially if they work unsocial hours. Managers and Matrons continue to promote and facilitate staff to complete training throughout the year as well as during employee reviews.
Update mandatory IPC training for clinical and non-clinical staff as per Trust training needs analysis to include; - Feedback on performance - Incidents including RCAs - Audit results	IPCT	Monthly	Green	Green	Green	Green	The electronic mandatory IPC training includes the requirements for level 2 training, however updates on KPIs and learning points from RCAs and incidences are provided through bulletins/notices and pictorial guides. The team has also provided training at ward level as part of the Trust's learning processes following audits and patient reviews e.g. COVID updates, PPE, C diff, Norovirus, device management, ANTT

To continue with the link worker educational programme; - Quarterly meetings. - IPCN to provide educational sessions to support link workers in their role. - Managers to allocate dedicated time for link workers to attend meetings and complete Hand Hygiene audits	IPCT Ward Managers	Quarterly	Amber	Amber	Amber	Amber	No formal sessions have been provided during 2021/22 mostly due to the restrictions of face to face meetings, however contact and information continues to flow through emails, bulletins and ward interactions. As the pandemic continues to subside there is a plan to revitalise the link worker programme and have the link workers be more evident on the wards in assessing and promoting IPC standards.
Provide ad-hoc training as required/need identified	IPCT	As required	Green	Green	Green	Green	As discussed above the IPCT have provided promotional and awareness training throughout 2021/22 the “bug bus” (decorated trolley with promotional materials), Team Brief Live, face to face ward visits, tabletop promotions outside the staff restaurants and training packages. Topics included: C diff, hand hygiene, equipment and environmental hygiene, PPE, Isolation, COVID, antimicrobial stewardship etc..
Staff Health and Wellbeing (Occupational Health) are standing members of the IPCAG and report employee incidences as related to IPC and review policies and guidance	IPCT Staff Health and Wellbeing	Quarterly	Green	Green	Green	Green	A representative from Staff Health and Wellbeing (Occupational Health) attends IPCAG meetings as scheduled and provides a report, they are also included in IPC Bronze meetings and Trust Silver meetings. Staff Health and Wellbeing have updated a number of their policies this year including vaccination, COVID and prophylaxis following staff exposures to potentially infectious diseases.
In collaboration with Procurement review equipment and consumables to ensure that purchases are cost-effective and meet IPC requirements	IPCT Procurement	As required	Green	Green	Green	Green	Procurement and the IPC team work very closely together on identifying suitable equipment that meets IPC requirements. This occurs during procurement meetings as well as during Silver Command and Clinical Review Group meetings, as well as ad hoc discussions as required.

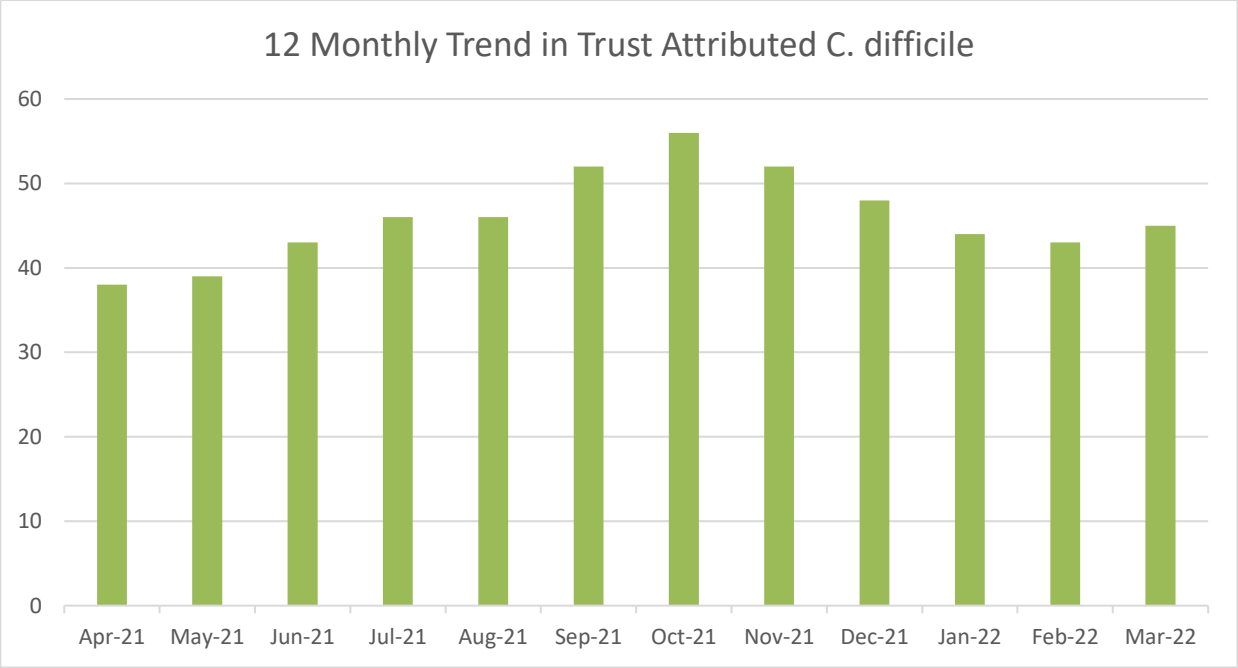
IPC KPIs and Related Actions

Clostridioides difficile Infections (CDI)

In 2021/22 the CDI objective set by NHSE was to have no more than 27 cases.

The end of year total was 43 exceeding the objective by 16 (the total includes both hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA) cases.

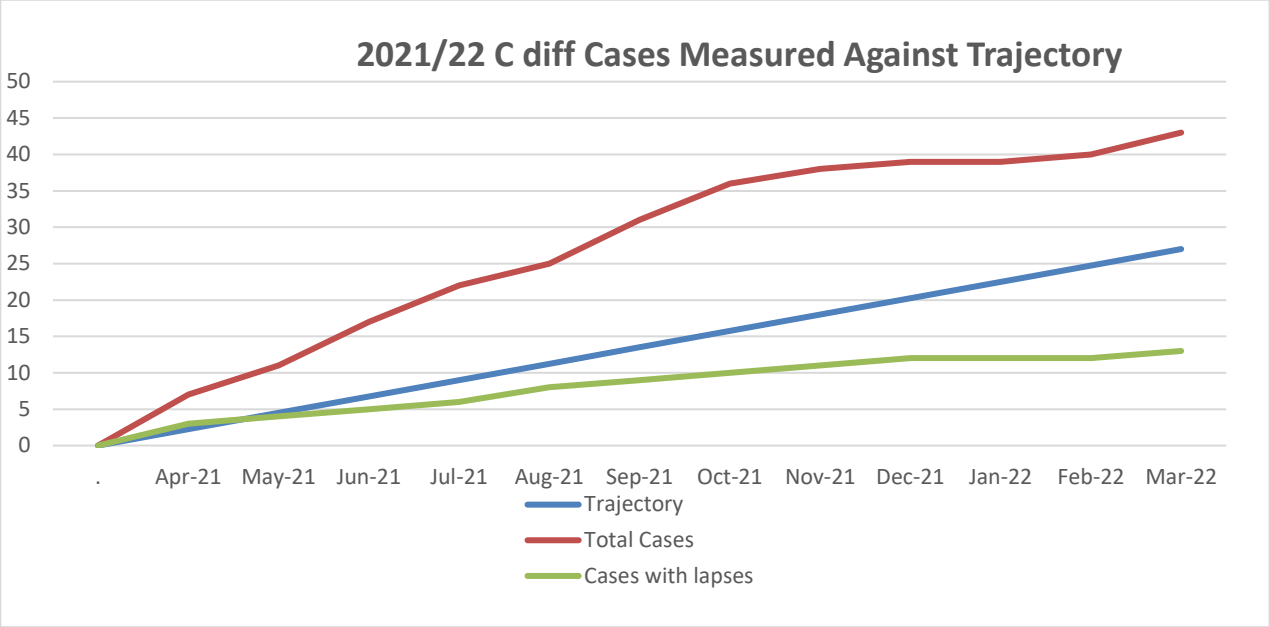
The chart below compares the month on month 12-month trend for 2021/22. This shows a gradual increase from April which reaches a peak in October with a gradual decline until March when the cases in this twelve-month period have a slight upturn.



C. diff. cases against trajectory 2021/22

Of the 43 cases 32 were HOHAs and 11 COHAs (HOHAs are cases that occur in hospital after day 2 of the patient's admission when day 1 is the day of admission – these are considered hospital acquired. COHAs are cases when the patient was discharged from hospital within 28 days of the sample being taken either in the community or on day 1 or 2 of a patient's readmission – these are still attributed to the hospital).

The chart below shows the cumulative monthly cases plotted against the monthly objective. It also shows the results of the RCA reviews and identifies how many cases had a possible lapse in care.



The RCA process acknowledges that not all C difficile cases are preventable; a patient may be appropriately reviewed and treated and still acquire CDI.

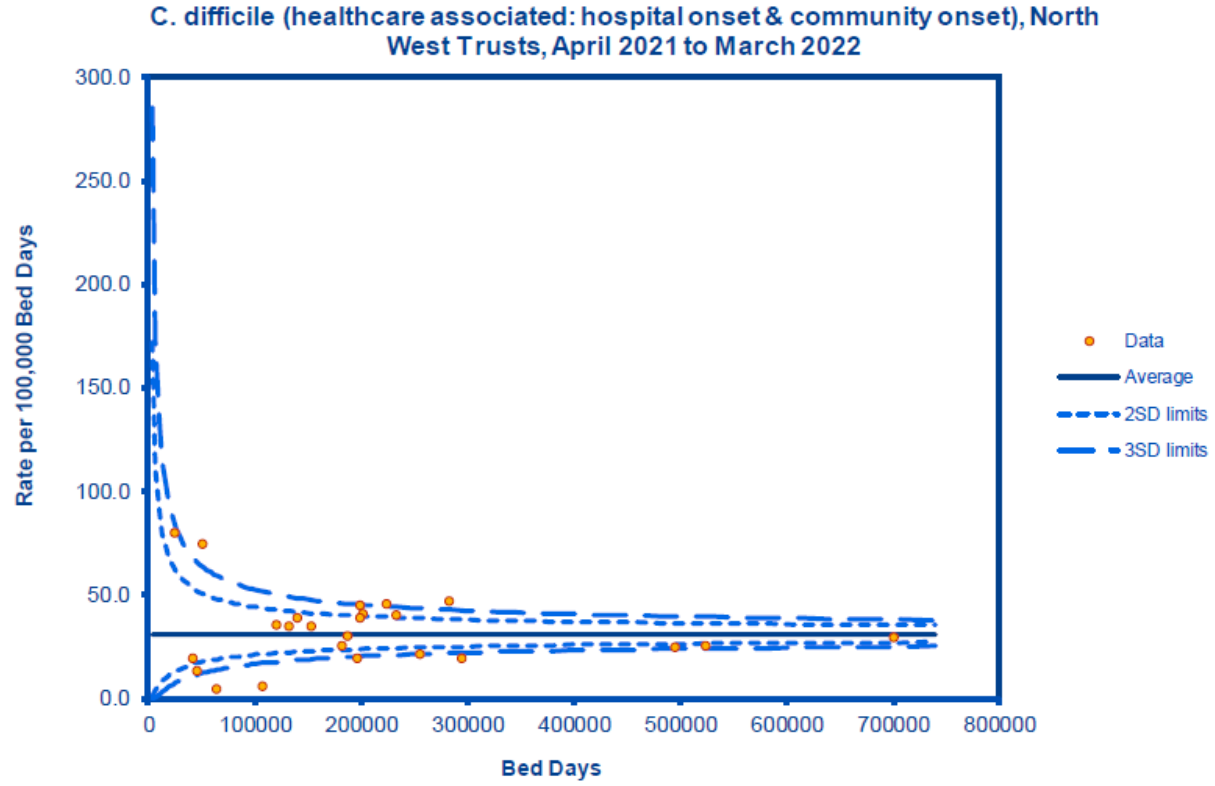
Some of the identified lapses may not directly culminate in CDI, but may, for example, put others at risk due to a delay in isolation of symptomatic patients, or may cause a delay in treatment as a result of a delay in acquiring a specimen. Other common themes include prolonged courses of antibiotics, or the use of broad-spectrum antibiotics without a clear indication.

The learning from these cases are fed back to the clinical staff as well as to the wider Trust through the Monthly IPC Performance Reports CBU Governance meetings – it is also included when developing medical or IPC training.

At the start of the year the Trust implemented a C difficile action plan which was monitored on a weekly basis in the Trust IPC Bronze meeting which included the CCG Quality Manager. The action plan was multifaceted and within time has started to reduce the incidence of CDI as observed in the 2nd and 3rd quarters.

Some of the reoccurring factors that cannot be accounted for in the action plan was the frailty of the patients with their associated co-morbidities. Another confounding factor noted in the Trust as well as in other Trusts was the general increase in antibiotic prescribing, hence this was one of factors targeted.

The UKHSA Northwest (NW) report in April 2022 reports the Trust has a C difficile rate of 35.7 per 100,000 bed days, the NW average is 30.9. The chart below taken from this report shows that the trust is within 2 standard deviations of the average with many Trusts experiencing significant increases.



Source: HCAI Data Capture System

Action: The actions within the C difficile action plan have been completed with some items such as use of pre and probiotics being discarded following the release of updated NICE guidance. Therefore ongoing actions for 2022/23 include continuing monitoring of antibiotic prescribing by ward pharmacists using Tenable, IPC and Soft & Hard FM audits of IPC standards and the environment, working collaboratively with the ICS and local care partners (in 2021/22 part of the Trust Action Plan that was accomplished was to provide training to CCG GPs in both West Lancs and Sefton), introduction of electronic prescribing, IPC & C diff ward rounds, antimicrobial ward rounds led by Antimicrobial Pharmacist and Microbiologist, education and induction of new doctors commencing August 2022 and continuing ward education by the IPC team.

MRSA Bacteraemia & MRSA Screening

Two patients had positive MRSA blood stream infections in 2021/22. One was on ward SSU and was previously known to be MRSA colonised. The patient was admitted with a diagnosis of sepsis and had a history of reoccurring sepsis primarily due to UTI, however blood culture on admission no growth; it was 5 days post admission that blood culture was repeated and found to be MRSA positive. The patient had numerous co-morbidities and had carers at home. On admission the patient was found to have psoriatic skin and had breaks in the skin due to pressure and leg ulcers. She also had intermittent catheterisation. An RCA was completed which included clinical ward staff, Microbiologist, IPCT, Associate Medical Director and CCG Quality Manager. The findings of the RCA were that the blood culture may have been a contaminant however she did respond to treatment. It was likely that if the blood culture was not a contaminant, then the source of the infection was the previous history of MRSA colonisation and the breaks in the skin. The patient received the requisite care, however only the basic MRSA screen was completed on admission which didn't include throat or wound sites. As a result of the RCA staff on AED and SSU received training on MRSA and MRSA screening from the practice education facilitator.

The second MRSA patient to become bacteraemic was an elderly gynaecology patient in January 2022 that had a vaginal prolapse. An RCA was convened as above and the patient's history reviewed. The conclusion of the RCA was that the patient had exceptional care and follow-up that was both thorough and compassionate. No lapses in care were identified and the patient was very satisfied with the treatment and surgical resolution of her medical condition.

The Trust remains a low-risk site for MRSA bacteraemia.

The Trust continues to screen new admissions for MRSA colonisation. Typically, more than 95% of eligible patients are screened either preadmission for elective patients, or in AED if an emergency admission. Missed screens are identified by the IPC team who request the ward to complete the screen if so required. Following the IPC team's implementation of, writing in the patient's case notes each new case of MRSA colonisation using a florescent label, subsequent audits have found high levels (>95%) of adherence to prescribing MRSA suppression treatment.

> **Action:** Trust to continue to test eligible patients for MRSA colonisation and provide suppression as required. The IPC team to continue to monitor screening results and will report to the ward coordinator any positives. The team will also place alert stickers in the case notes of positive patients and monitor MRSA pathways.

MSSA Bacteraemia

The number of MSSA bacteraemia in 2021/22 was 15 which is an increase from last year figures, however when compared with the NW average the trust is slightly above the average but well within two standard deviations.

The source of these infections were varied making it difficult to focus on one or two causes as these ranged from skin related infections and pneumonias being the slightly more frequent, to single cases of hepatobiliary or surgical site infection sources. Looking at the RCAs for these infections there were no significant lapses in care and most likely related to the patients chronic conditions that may have exacerbated or promoted these infections – 3 of these patients were coinfected with COVID.

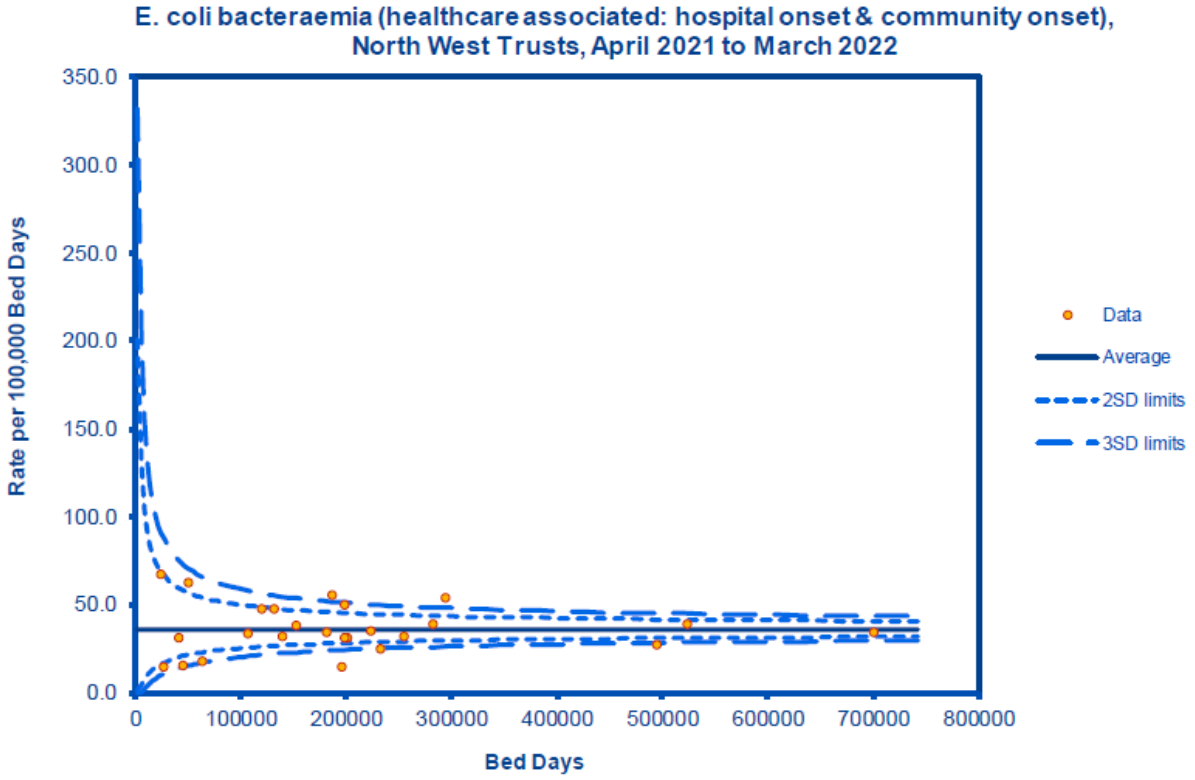
> **Action:** Continue with surveillance and note any trends. As this is an organism that is able to contaminate IV access devices the Trust has once more determined that cannula care, placement, management and recording will be a priority for 2022/23 and will consider the most appropriate equipment for this purpose and access to the best educational materials and providers.
>
> The Trust is also committed to promoting and providing good mouth care to patients especially if they are unable to do this for themselves and the Tissue Viability nurses are actively involved in promoting pressure ulcer prevention and wound care.

E coli Bacteraemia

E coli continues to be the most common bacteria to cause bacteraemia with the primary source being urinary tract infections and catheter associated urinary tract infections.

As with CDI NHSE considers hospital acquired infections as HOHAs and COHAs and has produced an objective for each acute Trust. The objective for Southport & Ormskirk was to have no more than 70 combined HOHAs and COHAs; this objective was met by having a total of 57 cases.

Remarkably the Trust rate per 100,000 bed days is only 47.3 which is against a background of Southport & Formby CCG being the highest in the NW for community acquired E coli bacteraemia. The NW average rate is 36.0, hence when reviewing the chart below it is evident that the Trust is still within 2 standard deviations of the average.



Source: HCAI Data Capture System

Action: There were several actions in 2021/22 that were not fully realised, these included completing a new catheter care plan and working with wards to reduce the number of catheters placed were possible and also reducing the length of time they are used - these continue to be objectives for 2022/23. Other considerations for the year include reenergising the Catheter Care group which will consider the use and content of catheter packs.

The other aspect of preventing blood stream infections caused by gram negative bacteria includes identifying the early onset of UTIs and treating these infections appropriately so that they don't lead to bacteraemia – hence another aim for the new year is working with prescribers to adequately assess for UTI and treat with the appropriate antibiotic, some of this will be signposted through Electronic Patient Prescribing as it comes online later in the year, but also includes obtaining the microbiological and other diagnostic evidence to confirm treatment plans.

Klebsiella and Pseudomonas Bacteraemia

In 2021/22 there were 15 Klebsiella hospital acquired blood stream infections this is a reduction of 4 from the previous year. In this same time period there were 7 Pseudomonas blood stream infections which appears to be a small increase however in the previous year COHAs were not combined with HOHA infections which has therefore increased the total by 4.

Klebsiella and Pseudomonas fall into the same gram negative bacteria category as E coli and the sources of infection are very similar. Klebsiella bacteraemia is second only to E coli for the number of hospital acquired bacteraemia.

The Klebsiella rate per 100,000 bed days is 12.5 which is below the NW average of 14.5. The Pseudomonas rate of 6.0 is just over the NW average rate of 4.6 cases per 100,000 bed days.

These infections tend to pray on the very vulnerable patients within healthcare facilities, hence it comes as no great surprise that hospitals in the region that treat a significant number of cancer patients have higher rates of these infections.

> **Actions:** The actions are the same as under E coli; the IPC team will continue to monitor trends and report to the UKHSA monthly figures.

CPE Screening

During this year 739 CPE admission screens were obtained from patients who were identified as being at increased risk of CPE colonisation. 1 patient was reported as hospital acquired on the Spinal Injuries Unit as the test was positive more than 2 days from their admission date, however the patient had been in a number of hospitals and extended care facilities prior to their transfer to Southport and had also required a number of courses of antibiotics. 3 other patients were found to be positive on admission screens having been transferred from the Walton Centre, Manchester Royal Infirmary and Victoria Hospital – Hong Kong. The positive cases verify the need to continue to screen patients from increased risk facilities.

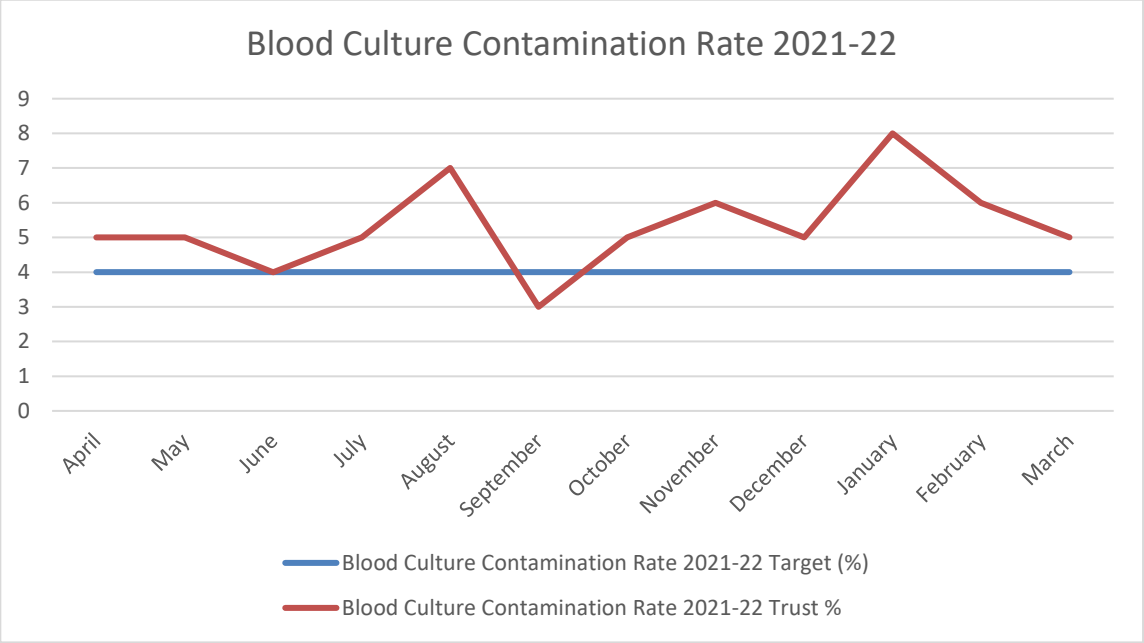
None of the cases were due to transmission within the Trust and the overall low number of CPE cases continues to identify the Trust as a low risk facility.

> **Action:** Continue to monitor for CPE colonisation and follow the UKHSA guidance. Consider screening amendments based on changing patterns. Work with partner organisations to identify potential cases and screen contacts.

Blood Culture Contamination

There will always be a potential for blood culture contamination, however this needs to be minimised through appropriate application of ANTT (Aseptic Non-touch Technique) otherwise patients will be inappropriately treated for infections they don't have which may lead to increased hospital stay or even risk of CDI.

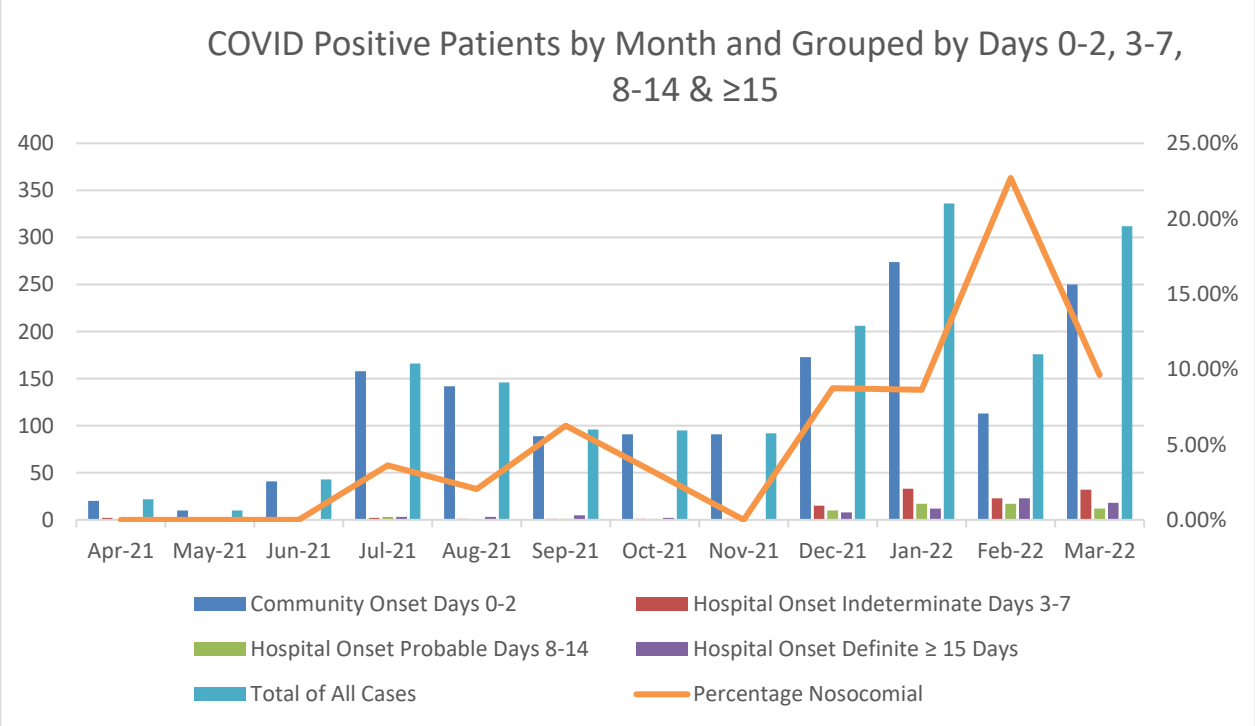
The chart below shows the blue line as the Trust target of no greater than 4% and the red line is the actual contamination percentage. Twice in the year the Trust has met the target then at other times the result has been close to the target, in August and January the result has been much greater than expected. More than half of the blood cultures are taken in AED, hence in addition to all doctors being trained in their clinical induction the focus for additional training is focused on AED. Hence, the peaks are usually followed by a concerted effort by the AED Practice Educators to monitor and train staff in the correct methods of taking blood cultures. In addition to the Practice Educators the Microbiology Clinical Scientist also provides feedback on contamination rates.



Action: The Medicine and Emergency care Practice Educators are to provide cyclic training within AED to maintain a more consistent low level of blood culture contamination. The IPC team will continue to monitor with the Clinical Scientist and provide feedback to the staff and alert the Practice Educators if monthly numbers appear to be increasing.

COVID-19

In 2021/22 the trust delt with 1700 patients that tested positive for COVID, this had a major impact on the Trust including the staff and patients, during this period there was a time when 4 of the wards on the Southport site operated as COVID wards.



The chart above presents a number of COVID measures including the monthly COVID positive totals and the breakdown of positives between 0-2 days, 3-7 days, 8-14 days and ≥15 days of their admission. This breakdown divides the cases into those most likely to have acquired their infection in the community (the 1st two groups) and cases that were most likely to have acquired their infections in the hospital (the last two groups). The chart also shows the percentage of cases that were likely to have acquired their infection in hospital.

The chart also shows the rise of the Omicron variant from November 2021 with the percentage of hospital acquired cases rising substantially illustrating how transmissible this variant was, even though many of the patients had few if any symptoms. The sharp increase in the percentage of hospital acquired cases in February was a result of the increased totals spilling over from January and the number of asymptomatic patients that tested negative on admission then tested positive on their day 3 or 5 post admission screens, leading to infections in susceptible patients that had been in hospital for more than 7 days, there were also a number of visitor interactions that likely led to patient infections that proceeded to further transmission.

During the previous year the Trust had purchased Redirooms (popup isolation rooms) and installed inter-bed space clear blinds between patient bed spaces. As the pandemic progressed it became more obvious that this virus could also spread through the airborne route of transmission therefore improved ventilation became a necessity which was problematic given the limited space between beds and that ventilation was based on the natural flow of air through open windows. Hence the next action was the installation of air purifiers and CO2 monitors in the wards and bays where space was particularly limited.

> **Actions:** As part of any new build or refurbishment consider ventilation and bed spacing at the design stage. Maintain the mitigation of inter-bed space isolation screens, air purifiers and CO2 monitors in areas that have poor ventilation and limited social distancing. Continue with the Trust Ventilation group as setup by IPC but have this led by Hard FM – this may take the form of a governance group within Hard FM that considers different aspects of the estate. IPC team to continue to monitor COVID levels as well as national guidelines and adopt changes as required by changing circumstances – continue as an active member of the NW IPC regional group as led by NHSE/I.

Gaps in Annual Programme and Actions

IPC team continued professional development

Due to the COVID pandemic many of the regional and national conferences have been cancelled - these events are an opportunity to network and develop new ideas as well as increase learning from peers and experts.

> **Action:** The Consultant Nurse and senior Clinical Nurse Specialist to identify national and regional events that they or other team members would be able to attend that would be profitable to then and the organisation. The IPC Matron to identify and enrol on a higher education course that will lead to a further leadership/education qualification leading towards a master's degree. The Clinical Nurse Specialist to complete their Manchester University post grad course in IPC and the Information Officer and Support worker to maintain their mandatory training supplemented by other training that will enhance their roles. | **Due: Completed by October 2022.**
> **Update:** Consultant Nurse has attended a regional event where he also gave a presentation – other conferences and events are now available and need to be booked. The IPC Matron has met with educational advisors but still needs to agree on a programme of study. The Clinical Nurse Specialist is nearing completion of their university course and after a period of consolidation will be considering further options and the Information Officer and Support Worker are current on their Trust learning objectives but will also consider additional learning opportunities.

IPC involvement in new builds and refurbs

Generally the Estates Capitol Team is very good at involving the IPC Team in any new capital projects, however there have been a few instances that the teams involvement would have been beneficial earlier.

Action: The Capital team to involve the IPC team at the inception of new schemes as well as continued involvement in project board meetings. | **Due: Completed May 2022.**
Update: The Deputy COO is now taking the lead in correlating projects, hence there has been implicit requirement for IPC involvement at the design stage of projects.

Clinical Coordinator (Bed Manager) IPC Training

The IPC Team works very closely with the Clinical Coordinators, however there have been some changes in personnel as well as many changes in procedures and application of IPC standards, hence there is the need for updating the group with the opportunity to discuss different scenarios especially since out of hours IPC advice is only through the on-call Microbiologist.

Action: Clinical Coordinators to invite representatives from the IPC team to one of their team meetings when the majority of the Clinical Coordinators are available to enable IPC training and discussion| **Due: Completed by August 2022.**
Update: Training session has been agreed, the Clinical Coordinators are in the process of arranging a venue and date.

Trust wide IPC training

IPC level 1 induction training meets the Trust target, however annual level 2 IPC training is just below the Trust target.

Action: ADONs and Matrons have communicated to staff the need to complete their IPC training and monthly updates are sent to managers from Education and Training identifying staff that require their annual update| **Due: Completed by August 2022.**
Update: IPC level 2 training is available on the intranet giving easy accessibility to all staff. The average compliance is 84% which is just below the 85% target. Managers Matrons and ADONs to pursue completion of staff training that's lapsed, or is about to lapse as identified by the Training & Education Department.

IPC Link Workers

Due to the COVID pandemic the IPC Link Worker face to face meetings haven't been held, however information has been sent via email, Trust News and individual contacts on the wards.

Action: Link Worker programme needs to be reenergised with each area having a Link Worker identified to not only complete or assign audits and give feedback, but also to provide advice within the level of their expertise. | **Due: Completed by September 2022.**

Update: Matrons and Managers have been asked to verify or assign an IPC Link Worker with the understanding that this needs to be someone that can complete IPC audits for their area as well as provide a basic level of IPC advice to their co-workers. The IPC Clinical Nurse Specialist has been tasked with producing this year's Link Workers training schedule which can be accessed face to face or by MS Teams.

Trust IPC Policies

For the last 2 years during the COVID pandemic the NHS has had a command-and-control structure from the centre which the Trust and the IPC team have responded to promptly with distribution of guidance through the Trust Comms structure. At the end of 2021/22 the

command-and-control structure became more relaxed with the assertion that this would become further relaxed in the coming months as further guidance was produced and the National IPC manual released. With these ongoing and proposed changes the Trust IPC policies now need to be updated inclusive of national guidance and with links to maintain their primacy.

Action: The IPC team is to review current IPC policies with reference to national guidance and insert appropriate links. Updated policies to be circulated to IPCAG and following amendments submitted for insertion to the Trust intranet. | **Due: Completed by August 2022.**

Update: The National IPC Manual has now been released which has superseded much of the previous national guidance. The IPC policy and Manual can now be updated to reflect this and for links to be inserted. MS Word copies of the IPC policies have been received and are now in the process of being reviewed.

Appendices

Appendix 1

	Surveillance programme 2021-22	Lead	Frequency	Progress update
1.	Mandatory surveillance for MRSA bacteraemia	IPCT	Continuous	Reported Monthly
2.	Mandatory surveillance of *C. difficile*	IPCT	Continuous	Reported monthly
3	Participate in National mandatory surveillance of Orthopaedic SSI	Trauma Nurse	Continuous	Reported monthly
4	Mandatory surveillance for E coli, Klebsiella, and pseudomonas bacteraemia	IPCT	Continuous	Reported Monthly
5.	Continuous surveillance for MSSA bacteraemia	IPCT	Continuous	Reported monthly
6.	Alert organism and condition surveillance	IPCT	Daily	Completed daily; Review on ICNet
7.	All organism bacteraemia surveillance with infection rates by ward	IPCT	Continuous	Reported Monthly
8.	Enhanced Surveillance in Critical Care (Central Lines and Ventilator-associated pneumonia)	IPCT Critical Care Lead	Continuous	Reported monthly
9.	Inoculation incidents	Staff Health and Wellbeing	Continuous	Reported quarterly
10	Central line associated bacteraemia in non-critical care areas	IPCT	Continuous	Reported Monthly
11.	Invasive medical device prevalence for all wards	IPCT	Weekly	Reported monthly
12.	Quantitative assessment of commode cleanliness	IPCT	Weekly	Reported monthly
13.	Sepsis Mortality review	Executive Medical Director	Continuous	As required
14.	SSI Surveillance for Caesarean Sections (development of systems)	IPCT Head of Midwifery	Continuous	Reported monthly
15.	Surveillance of significant communicable organisms as part of enhanced surveillance e.g. COVID-19, influenza	IPCT	Continuous	Reported monthly and as required

Appendix 2

	Audit programme 2021-22	Lead	Frequency	Progress update
1.	Hand hygiene	IPCT Link practitioners	Monthly	Reported monthly
2.	MRSA screening compliance for elective & emergency admissions	IPCT	Monthly	Reported monthly
3.	Contamination of blood culture specimens	IPCT	Monthly	Reported monthly
4.	Compliance with MRSA Pathways	IPCT	Weekly	Reported monthly
5.	Compliance with C. difficile Pathways	IPCT	Weekly	Reported Monthly
6.	Hand gel availability	IPCT	Bi-weekly	Reported monthly
7.	Antibiotic audits	Antimicrobial Pharmacist	Monthly	Reported Monthly
8.	Antimicrobial point prevalence audit	Antimicrobial Pharmacist	Quarterly	Reported quarterly
9.	Compliance with cannula care plan	IPCT	6 monthly	Reported bi-annually
10.	Compliance with catheter care plan	IPCT	6 monthly	Reported bi-annually
11.	PPE audit	IPCT	monthly	Reported monthly
12.	IPC Ward and department IPC inspections	IPCT	Revolving programme	Reported monthly
13.	IPC Perfect ward audits	IPCT	Revolving programme	Reported monthly

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO131/22**	**FOI Exempt**	**NO**
Report Title	**SAFEGUARDING ANNUAL REPORT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Sharon Seton, Associate Director of Safeguarding		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The Safeguarding Annual Report for 2020/21 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 01 April 2021 to 31 March 2022 and to provide assurance that the Trust has robust processes in place to safeguard those who use Trust services and to highlight areas of challenges in safeguarding provision.

Executive Summary

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

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

The Trust's Safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the unborn, children, young people and adults who are at risk of abuse or neglect.

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

This report demonstrates the work Southport and Ormskirk (S&O) NHS Trust has in continuing to fulfil its responsibilities to safeguard children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults, including the Mental Capacity Act (MCA) during 2020-2021. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs). These Boards aim is to ensure agencies in Sefton and Lancashire are working together effectively to keep children, young people and adults safe. The aim of this report is to provide an overview of the key developments, progress, achievements and challenges for the Safeguarding Team.

Southport and Ormskirk Hospital NHS Trust

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

NHS
Southport and
Ormskirk Hospital
NHS Trust

Safeguarding Team Annual Report 2021/22

Author: Sharon Seton

Assistant Director of Safeguarding

Contents

Glossary of terms

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

1.0 EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2021 / 2022 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2021 – 31st March 2022. The purpose of the annual report is to inform the Southport and Ormskirk NHS (S&O) Trust Board of safeguarding activity, providing assurance to the Trust Board that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

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

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

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

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

1.6 **Key roles of the team include:**

- We provide support and an extensive safeguarding knowledge to all staff across the Trust.
- We provide daily operational responsibility for safeguarding concerns, recognising when a concern may require referral to external partners.
- We provide a Trust contact for the Local Authorities and all other external agencies, for the process of referrals and for the sharing of relevant information.
- We work with partner agencies to ensure the decisions and processes support the ways of working for an acute trust.
- We lead and ensure a Trust-wide culture that supports staff in identifying and raising safeguarding concerns.
- We participate with Local Safeguarding Board processes to learn lessons from cases where the un-born, children or adults die, or are seriously harmed as a result of abuse.
- We ensure engagement with Local Safeguarding Boards and any local arrangements for safeguarding both adults and children.
- We ensure Trust staff access training that is complaint to the intercollegiate documents for safeguarding adults and children; monitoring and improving compliance and escalating as appropriate.

- We ensure the Trust works and is compliant with legislation and statutory responsibilities

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

1.8 From the quarterly submission of key performance indicators (KPIs) to South Sefton Clinical Commissioning Group (CCG), the Trust achieves a RAG rating of green in relation to Local Authority children and adult referrals, Mental Capacity Act and deprivation of liberty safeguards (DoLS), and in Q4 achieved a compliance >90% in all six levels of safeguarding training.

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

2.0 INTRODUCTION

2.1 The team structure is set out in Appendix 1, with the statutory roles of the Named Nurse for Adult's and Named Nurse for Children's reporting directly to the Assistant Director Safeguarding. The statutory role of the Named Midwife reports directly to the Named Nurse for Children's.

2.2 As detailed in the Safeguarding Children and Young People: roles and competencies for healthcare staff intercollegiate document (2018), the Trust has a Named Doctor for child protection. The role incorporates supporting colleagues with safeguarding concerns and undertaking safeguarding training. The enhanced medical training consists of 3 monthly peer review sessions, and 6 monthly peer review of child protection medical reports, which is also included in the new trainee's training. The Named Doctor attends monthly safeguarding huddles with the safeguarding team and attends the Safeguarding Assurance Group.

2.3 In accordance with local safeguarding children's board child death processes and detailed in Working Together to Safeguard Children (2018), the Trust has a Designated Doctor for child deaths, who is a senior paediatrician, and takes a lead role in the child death review process.

2.4 The safeguarding team has continued its journey of improving safeguarding arrangements within the Trust throughout 2021/22. The team continue to strive for continuous and sustained improvement, in relation to the safeguarding policies being in place, training compliance, and responding proportionality and in a timely manner to safeguarding concerns.

2.5 Key Achievements in 2021-2022

- We developed and introduced a Service Level Agreement with Merseycare, to provide a Mental Health Administration Service for patients detained under the Mental Health Act
- We developed a Memorandum of Understanding with Light for Life Homeless Service
- We achieved >90% compliance in all six levels of safeguarding training
- We recruited through NHSP a 0.6 wte Learning Disability and Autism Practitioner
- We developed a business case for a 1.0 wte substantive Learning Disability and Autism Practitioner
- We provided senior Trust representation in Lancashire and Sefton at forums relating to the planning and preparation of the implementation of the LPS process
- We recruited to the vacant post of Safeguarding Administrator
- We provided ongoing collaboration with IT to develop the MCA and DoLS portal
- We provided collaboration with the datix team to develop the electronic safeguarding adult's referral form
- We ensured the provision of a report into the daily bed meeting, detailing patients detained under the mental health act
- We implemented the 'Care of 16 -17-year-olds in an Adult Hospital' SOP
- We implemented daily contact with wards and AEDs when they have <18's to ensure the use of the SoP, and to identify if there are any safeguarding concerns
- We had the covid dashboard updated to include an icon to identify those aged 16-17 years old
- We introduced safeguarding drop-in sessions for paediatric staff
- We established a monthly CAMHS and Southport and Ormskirk Trust relationship meeting
- We adhered to the 'S42' Memorandum of Understanding developed with Sefton Local Authority
- We continued delivery of training to a network of safeguarding ambassadors
- We reviewed and implemented revised policies
- We streamlined the children's databases to ensure relevant and accurate data is available
- We facilitated training for the partnership via the training pool for Sefton
- We supported the implementation of revised safeguarding referral forms for Lancashire
- We supported the implementation the New Model of Working Well with Families in Lancashire
- We continued to support with relaunch of Children and Family Wellbeing Service (CFWS) (Lancashire) and Early Help Offer (Sefton)
- We processed a 19.5 % increase in DoLS authorisations
- We provided 100% compliance in the MARAC process (multi-agency risk assessment conference)

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

Safeguarding children's link nurse	Attends steering group and links into safeguarding children team
Safeguarding ambassadors	Launched January 2020 across the Trust to support sharing information and disseminate training/lessons learned
Representation at the planned and unplanned governance meetings	Core agenda item at the monthly meeting
Included in Trust news	7-minute briefings / Local SCB and Local SAB newsletters / /safety notices / safeguarding ambassadors / links to Local SABs
Safeguarding Briefs	Newsletters circulated to all L3 children's leads to disseminate within their teams External training circulated to all L3 children's leads to disseminate to their teams.

3.0 GOVERNANCE ARRANGEMENTS

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

3.2 A quartile KPI report is submitted to South Sefton CCG, after which the CCG provide an assurance report for the Trust. The Assistant Director of Safeguarding undertakes business meetings with the Designated Nurse and Designated Practitioner for South Sefton CCG. The meeting occurs prior to the SAG meeting and the purpose is to review the KPI return for the previous quarter. The KPI return feedback is an agenda item at the Trust Contract & Clinical Quality Review Meeting (CCQRM), which the Assistant Director of Safeguarding attends when requested.

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

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

4.0 ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Director of Safeguarding provides membership at both the Lancashire and the newly formed Sefton LSAB. In Lancashire and Sefton, the providers do not attend the Local Children's Safeguarding Boards, although the Assistant Director of Safeguarding provides Trust representation at the Safeguarding System Leaders meeting for both Sefton and Lancashire. Membership at the Boards ensures that the Trust is sighted on all aspects of the safeguarding agenda, and attending the Board allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards.

4.2 The Assistant Director of Safeguarding, Named Nurses and safeguarding practitioners represent the Trust at both Lancashire and Sefton Local SAB and Local SCB/CSAP sub-groups where representation is required.

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

- Sefton Process, Practice and Messaging
- Sefton Quality and Audit
- Sefton Mental Wellbeing
- Sefton Learning from Review, Development and Skills
- Sefton Health System Leaders Meeting
- Lancashire Mental Capacity and Deprivation of Liberty Safeguards
- MARAC Sefton
- Sefton Channel Panel
- Sefton SEND Improvement Group
- Sefton Domestic Abuse Partnership Board
- MARAC steering group
- Sefton and Lancashire LEDER Operational Group
- LEDER Review Panel Meeting
- Sefton and Lancashire LPS Implementation Steering Group
- Lancashire Health Providers Forum

It is worth noting that the Lancashire Adult Board had little representation from providers following the re-organisation of their sub-groups. This has been challenged and representation at the sub-groups has been requested by the providers.

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

- Lancashire Connectivity meeting
- Sefton MACE
- Sefton Multi Agency Audit group
- Lancashire Multi Agency Audit group
- Lancashire MARAC
- Lancashire MARAC Working Group
- Northwest Named Midwife Regional meeting

- Lancashire CSAP Tactical Group
- Lancashire Family Safeguarding Operational Group
- Lancashire MASH Q&A
- Sefton LSCB training pool
- Sefton LSCB L & D subgroup
- Sefton Policy and Procedure subgroup
- Sefton CE strategic subgroup
- Sefton CE Health group
- Lancashire SUDCI Liaison meeting
- Lancashire CDOP
- Sefton CDOP
- Sefton LAC Collaborative Task and Finish Group
- CSAP Task and Finish group 'Children whose Medical needs are Neglected'
- Sefton MASH Health Meeting

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

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

4.6 The Named Midwife is a member of the National Maternity Safeguarding Network and attends meetings monthly at Northwest regional Meeting. The named Midwife has contributed via a task a finish group to a review of the pre-birth assessment in Lancashire, which is now published on the Lancashire CSAP website. The Named Midwife is a member of CDOP for both Lancashire and Sefton and is represented on both CDOP panels. The Named Midwife is a member of Early Help Partnership for Sefton. The Named Midwife attends monthly meetings with Sefton & Lancashire Children's Social Care Managers, in order to discuss and review referrals and open cases in relation to the un-born. The Named Midwife attends the Children's Safeguarding Connectivity Meeting with designated professionals from Lancashire CCG. The Named Midwife has updated the internal Child Death Process. The Named Midwife has been involved in discussions and workshops with Lancaster University, Lancashire Trusts and Lancashire Partnership, following a research project looking at babies born into care and best practice principles.

4.7 The safeguarding team provide 100% representation at all requested strategy meetings, child protection conferences and core group meetings. Reports for these meeting may be provided verbally, written or via email, as requested. The safeguarding team support the SAR/CSPR process by providing requested chronologies; providing panel membership; ensuring participation at practitioner events. The safeguarding team provide representation at local MACE, CDOP and MARAC meetings. Prior to the meetings the team complete all requests for information within the given timeframe, and subsequent actions from these

meetings are completed. The safeguarding team will support clinical staff to complete court reports, and the team ensure all reports are quality assured prior to submission.

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

5.0 TRAINING COMPLIANCE

5.1 By Q4 compliance had been achieved in all six levels of safeguarding training which consists of children's level 1, level 2, level 3 and adult's level 1, level 2, level 3. This has not been evident for several years and has taken a considerable amount of collaborative work between the by the practice educators, staff, and the Safeguarding Team. The compliance for children's level 3 was achieved ahead of the trajectory submitted to the CCG.

5.2 The mental capacity training has not achieved the required 90% in the past 6 months. Level 2 consists of three modules and is undertaken by most clinical staff. Level 3 consists of five modules and is mostly undertaken by the medical staff, as it includes a module on consent. This level of training is not currently mandated.

5.3 There are 12 Executive and Non-Executives in the trust training report and the Executive Board are compliant at 91.7%.

Table 1: Southport and Ormskirk NHS Trust Safeguarding Training Compliance

Overall Trust Compliance	Oct	Nov	Dec	Jan	Feb	March
Safeguarding Adults Level 1	93.1%	94.3%	93.7%	94%	93.2%	93.7%
Safeguarding Adults Level 2	91.99	90.9%	91.5%	93.3%	92.8%	91.3%
Safeguarding Adults Level 3	90.33%	100%	100%	100%	96.6%	96.4%
Safeguarding Children Level 1	93.8%	94.4%	94.2%	94.5%	94.5%	93.9%
Safeguarding Children Level 2	89.5%	88.3%	89.7%	90.6%	91%	90.7%
Safeguarding Children Level 3	72.1%	74.4%	78.4%	82.4%	82.4%	92.8%

Mental Capacity Act and Deprivation of Liberty Training

Overall Trust Compliance	Oct	Nov	Dec	Jan	Feb	March
Mental Capacity Level 2	84.23%	83.5%	86.6%	87.5%	87.8%	86.9%
Mental Capacity Level 3	65.25%	63.9%	64%	62.0%	62.9%	63.2%

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

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

5.6 Face-to-face training has resumed for level 3 children's training, although those staff who are non-compliant can complete a PowerPoint with additional notes, that is updated each year.

5.7 In addition to the training above the Safeguarding Team delivery bespoke training to:

- Doctors' induction - general safeguarding and MCA and DoLS
- International Nurses - MCA and DoLS
- Intensive Care - general safeguarding and MCA and DoLS
- Dementia and Delirium course - MCA and DoLS
- Paediatric Departmental Teaching

5.8 All relevant Local Safeguarding Board Training is shared through social media, Trust news and the Children's steering group.

5.9 The Named Nurse for Adult's has facilitated the safeguarding ambassador's role for approximately 66 staff across the Trust. It is the ambition of the team to have in all clinical areas at least one ambassador, who will receive additional awareness training in a range of subjects, in order that they are equipped to support the safeguarding agenda in their work area. Topics to date have included: mental capacity and DoLS; self-neglect; domestic and sexual abuse; children's safeguarding.

5.10 Safeguarding children's training is reviewed yearly and the themes this year have included: Social Care and Early Help referrals; criminal exploitation and assaults; voice of the child; children in care; domestic abuse; fabricated and induced Illness; neglect, adolescent neglect; CSPRs; medical neglect; impact of Covid; ICON.

5.11 The safeguarding team attend an array of multi-agency training to maintain their compliance to level 4 training. This year training undertaken includes restorative supervision, trauma informed practice and resilience.

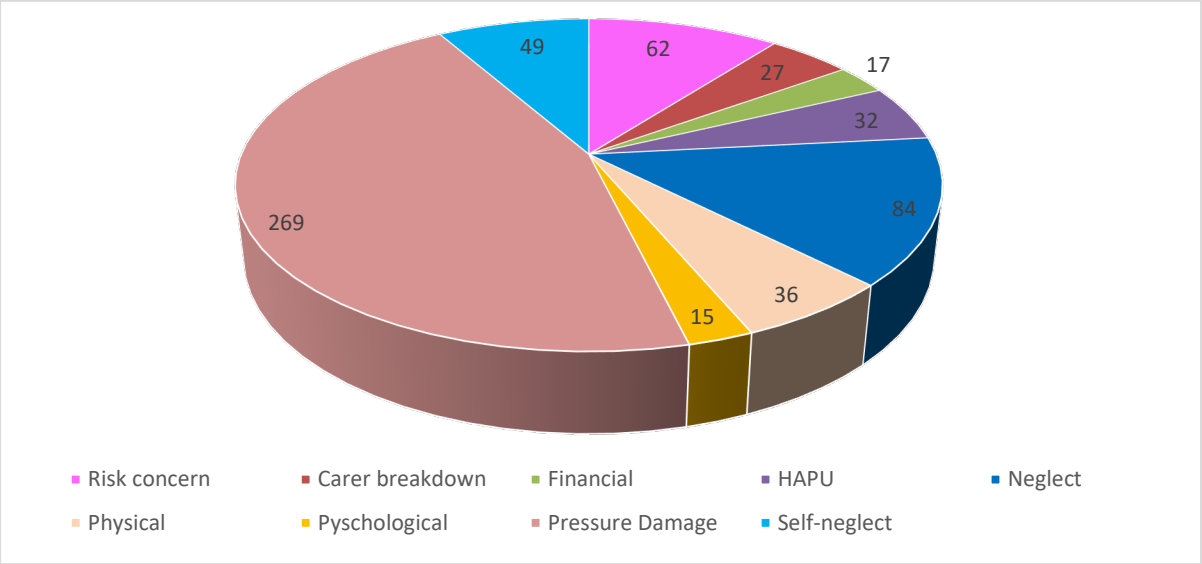
6.0 SAFEGUARDING ACTIVITY

6.1 Adults

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

6.3 In 2021/2022 there have been 850 DATIX safeguarding concerns (Table 2), including 161 for domestic abuse and 98 for sexual abuse. In addition, there has been 1713 applications for a DoLS authorisation, and this reflects a 19.5% increase compared to 2020/2021, and this is comparable to previous years that have seen a year-on-year increase in DoLS authorisations.

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



6.4 Data shows that 131 out of 591 concerns raised (excluding domestic abuse and sexual abuse) required a referral to a Local Authority (LA). It is worth noting that not all referrals to the LA would have progressed to a safeguarding inquiry under S42 of the Care Act, 2014.

6.5 For adult safeguarding referrals, other than in an emergency when the LA 'duty team' will be contacted, staff complete an internal referral form which is then attached to the datix. All safeguarding concerns will be quality assured and checked by the safeguarding team prior to submission to the LA; again, this excludes emergency safeguarding concerns out of hours. This year the team collaborated with colleagues in IT to design an e-referral form, however, it was suggested datix may be an alternative and more streamlined solution. In view of this a first draft has been developed and is in the process of being reviewed.

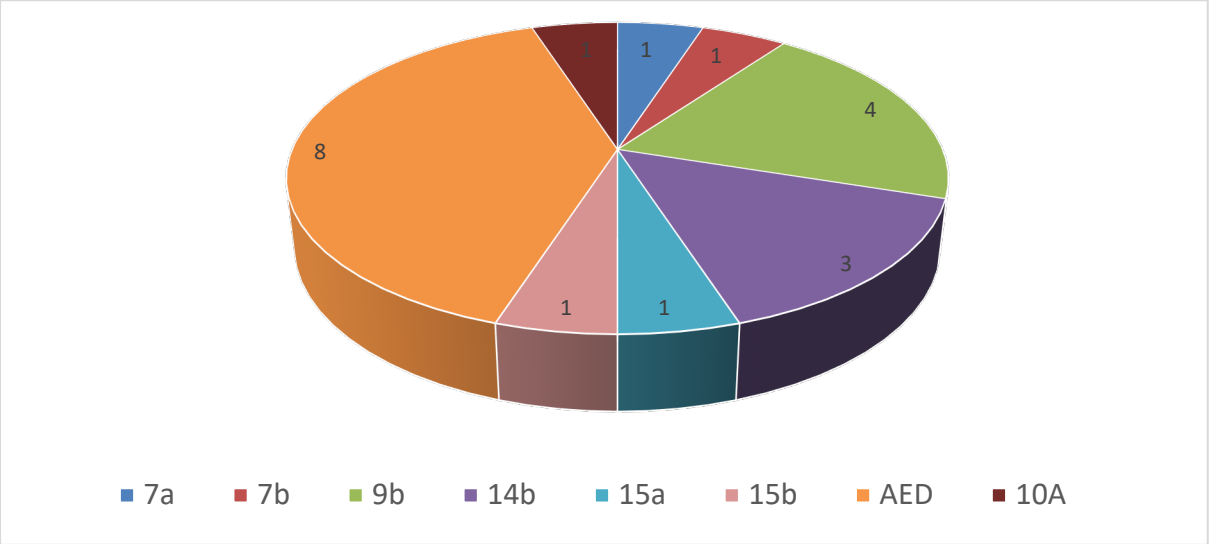
6.6 The adult team oversee two work-streams in terms of safeguarding referrals. The first relates to safeguarding alerts made by frontline staff. These are captured through the datix system, as staff are requested to complete an incident report when they identify a safeguarding concern. The second relates to safeguarding concerns raised against the Trust. These are investigated by the Local Authority under Section 42 of The Care Act 2014.

6.7 All S42s against the Trust are sent from the Local Authority Safeguarding Team to the Trust's adult safeguarding team, who oversee the investigation and liaise with the Local Authority regarding the outcomes. In 2021/2022 there has been 20 S42 concerns raised against the Trust, this is a decrease of 53% from the previous year. This is partly due to the Memorandum of Understanding that is in place with the Local Authority. This results in the Safeguarding Team and the Local Authority Safeguarding Team meeting regularly to ascertain

the best course of action for when a safeguarding concern is raised, as not all concerns raised meet the criteria for a S42.

6.8 The themes from the S42s remain relatively consistent and are mostly in relation to concerns raised during the discharge process. All concerns raised against the Trust enter the 'harm-free' care process and are presented at the weekly 'harm-free' care meeting, to provide oversight of the investigation, learning and subsequent actions.

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



6.9 Making Safeguarding Personal

Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 26 individuals who had capacity to refuse intervention, and a referral was not made.

6.10 Children and Young People

In 2021/2022 the children's team were involved with 1371 referrals including Children's Social Care (CSC), early help, information sharing and courtesy calls (Table 4). The themes identified in the referrals are detailed in Table 5.

Following a referral and after meeting the criteria for a 'children and family assessment' the child is identified as:

- that the child is not 'In Need'. In this case, Children's Services will take no further action other than, where appropriate, to provide information and advice in accordance with the local Common Assessment Framework.
- that the child is 'In Need', but it has been determined that the child is not suffering, or considered likely to suffer, significant harm. In this case, Children's Services will

determine the support which will be provided and draw up a 'Child In Need' plan accordingly.

- that the child is 'In Need' and that there are concerns that the child is suffering, or considered likely to suffer, significant harm. In which case, Children's Services will initiate a Strategy Discussion to determine whether a Section 47 investigation is necessary; and consider whether any immediate protective action is also required.

6.11 CSC do not routinely share the outcomes of referrals; however, this has improved as the team actively chase these outcomes therefore for 21/22 it not known exactly how many of the Trust's referrals proceeded to a 'child in need' and or S47. For the outcomes that have been received 95 proceeded to a children and family assessment (CAF), and 13 referrals resulted in a S47 order. In this year, the Trust undertook 9 child protection medicals, which can be used as part of a S47 investigation.

6.12 The team provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. This year the team have provided representation for at least 194 meeting. These have included but not limited to:

- 39 Strategy meetings
- 13 Initial Child Protection Conferences
- 3 Review Child Protection Conferences
- 5 Child in Need meeting
- 14 Core Groups meetings
- 22 Discharge meetings
- 5 Professionals meetings

Table 4: Safeguarding Referrals (including early help), Information Sharing, Courtesy Calls to Children's Social Care

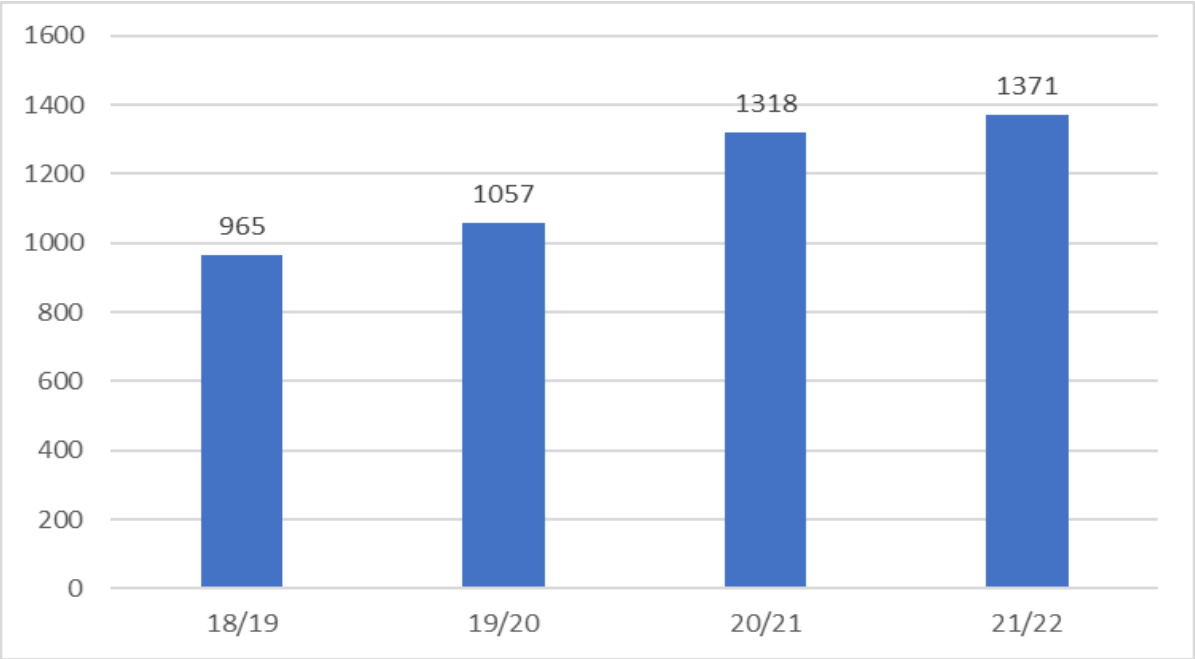
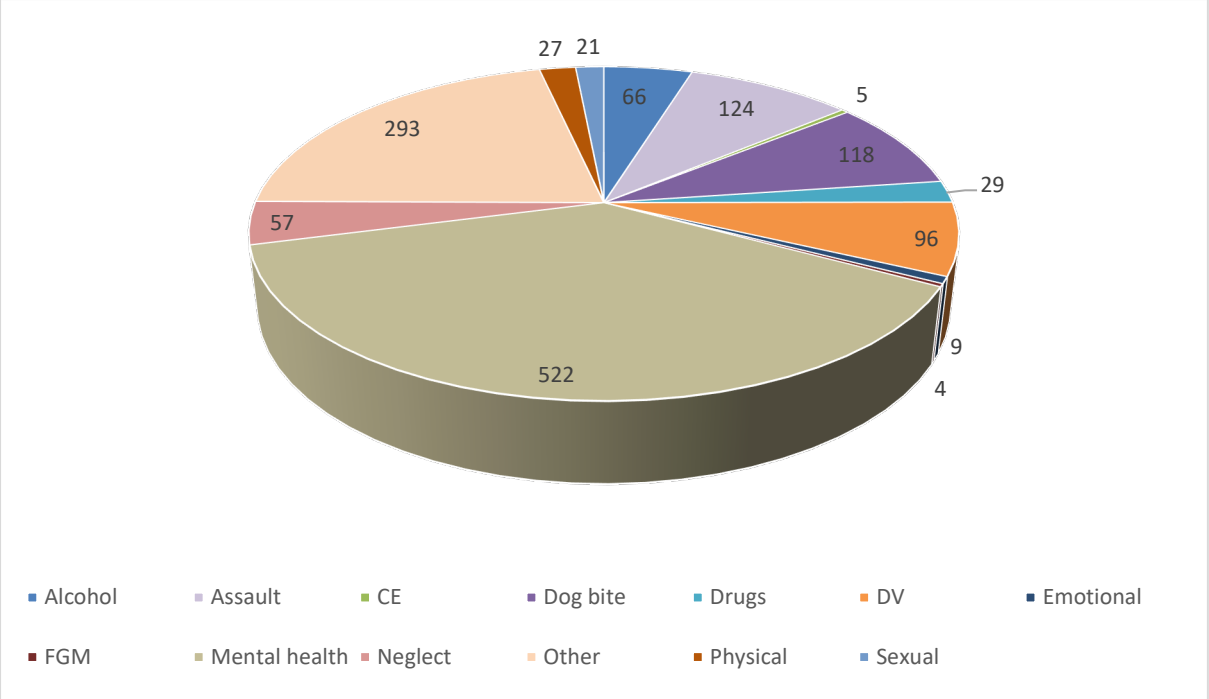


Table 5: Referral Theme by Primary Reason where this is recorded



6.13 This year has seen a 122% increase in the number of referrals relating to mental health. This is further evidenced as the team have extensively been involved in cases relating to the mental health and behavioural concerns of children and young people. This was highlighted when a review of 20 days from 19th February 2022 to March 10th, 2022, demonstrated the team were involved with 10 children and young people who presented during this time, and in the same period the team attended 15 care and or discharge planning meetings in relation to these children and young people.

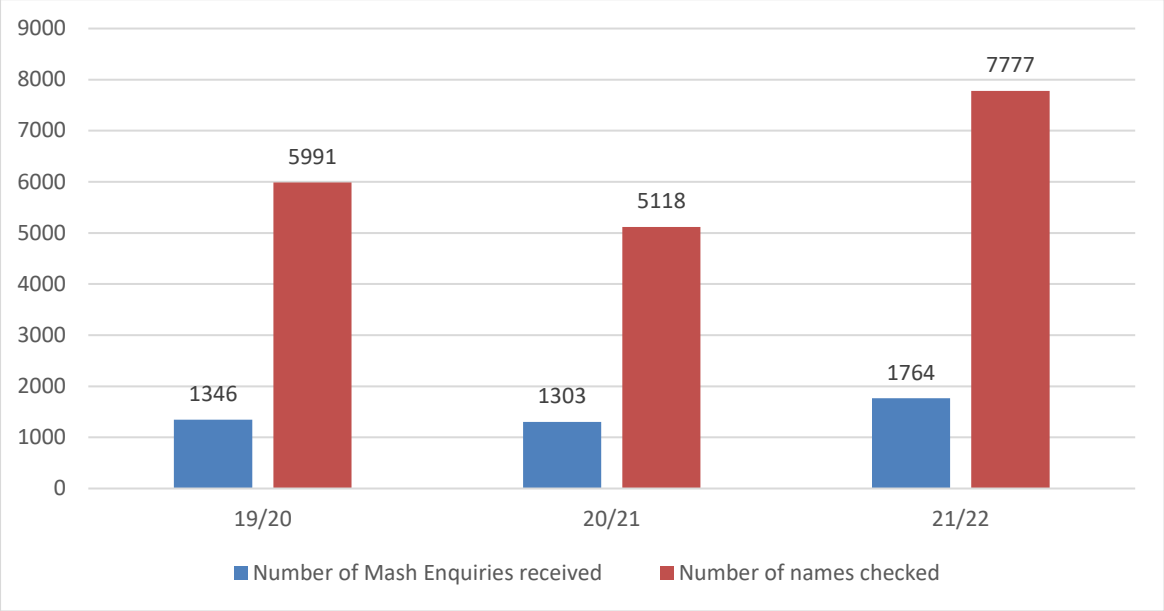
6.14 This year the team have made focused improvements in the use of both the dog bite proforma and the assault proforma. As a result, there has been a 34% increase in the number of dog bites incidents referred, and a 124% increase in the number of assault incidents referred.

6.15 The children's team is required to provide an extensive amount of safeguarding information to external agencies, (Table 6). This year has seen a 51.9% increase in the number of requests for information to the team. To deliver this information in a timely manner, the team has a 'duty 1' and 'duty 2,' with one duty responding to internal operational concerns, and the other duty responding to external requests for information. The team has been commended for their responsive and timely return of this information.

6.16 A single request for information can involve searching the clinical records of a number of patients, as the search can include a child, their siblings, their parents, grandparents and other members of the extended family. Recognising the impact of this, the MASH team had previously streamlined their process by only requesting information for relevant individuals,

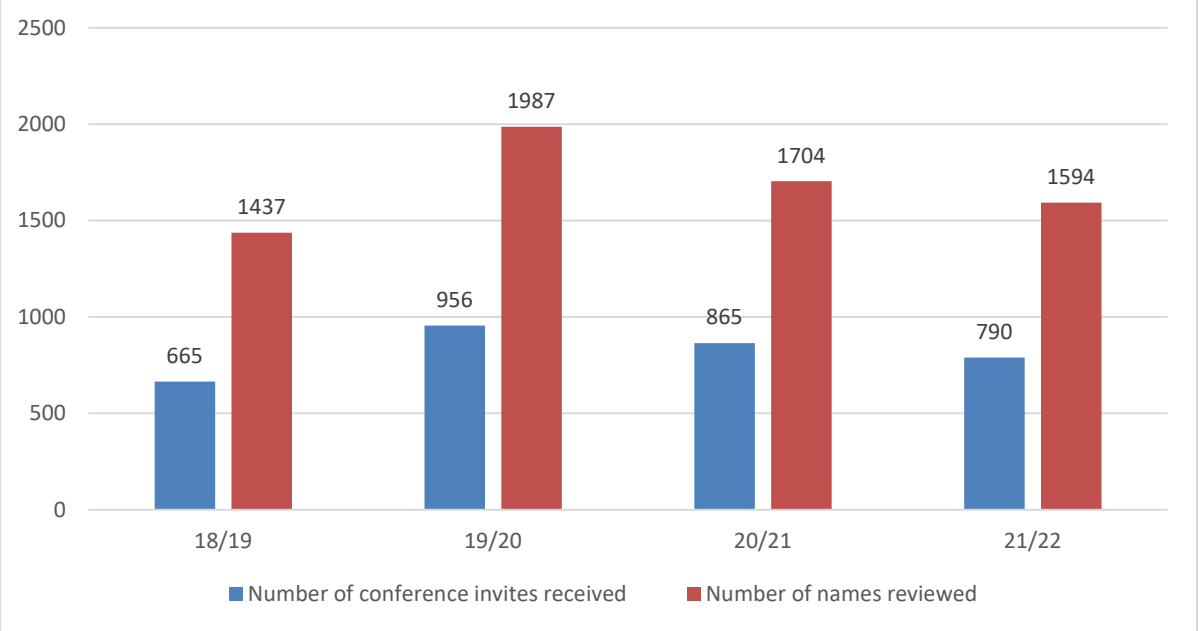
and by asking for information only dating back 2 years, (this is reflected in table 7). As an extra assurance the safeguarding practitioners will use their professional judgement, as to whether to disclose information dating back further than 2 years.

Table 6: Multi-agency Safeguarding Hub Requests for information



6.17 This year the children's team have received invites to over 790 case conferences, (Table 7), resulting in over 1594 children's clinical records being reviewed. This number is in fact higher, but the database was not updated during the period of recruitment to the safeguarding administrator post. It is also worth noting the number of records checked can be much higher as this does not include the parents' records and significant others records that are also searched.

Table 7: Case Conference Invites and Requests for Information



7.0 CHILD DEATH OVERVIEW PANEL (CDOP)

7.1 The Named Midwife and Named Nurse Children are CDOP Panel Members. The Trust meets its requirements in relation to the Local Safeguarding Children's Board child death processes, for both Sefton and Lancashire. During this year, the Trust has received 64 child death notifications, which is an increase of 64% from the previous year.

7.2 Of these children, 20 were known to the Trust which is a 186% increase in the requirement to review their clinical records. Despite this significant increase in accordance with the CDOP process, all requests for further information were returned within timeframe, whether the child was known or unknown.

8.0 DOMESTIC ABUSE and SEXUAL ABUSE

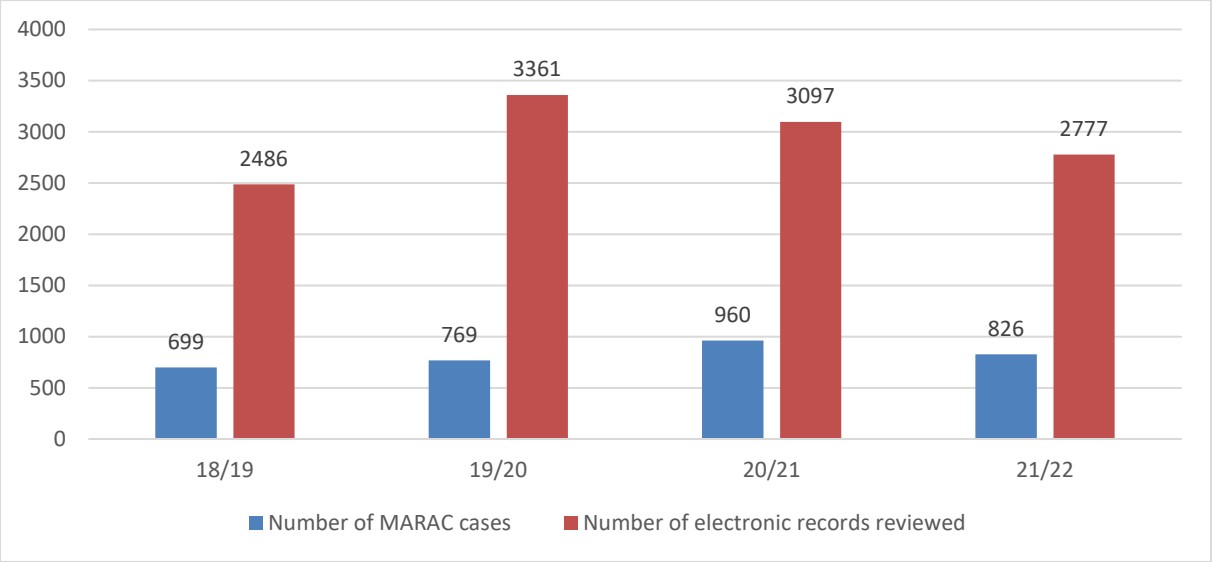
8.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and domestic abuse is recognised under The Care Act 2014 with its own category. In 2020 there were 2.3 million adults aged between 16-74 who experienced domestic abuse (ONS, 2020). The Domestic Abuse Act 2021 came into force following the Domestic Abuse Bill being agreed by the House of Commons and the House of Lords 2022, and receiving Royal Assent. The Domestic Abuse Act is the first act to provide a legal definition of 'Domestic Abuse'. The Act allows for wider recognition in relation to domestic abuse related crimes as well as recognition to victims, survivors, and perpetrators. It emphasises that Domestic Abuse is not just physical violence, but it can also be emotional, controlling, coercive and economic abuse. Following the publication of the Act, the team updated the Domestic Abuse Policy accordingly.

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

8.3 The Trust has sustained 100% attendance at the MARAC meetings this year in Lancashire and Sefton, of which there are 3 per month. The Trust further achieves 100% compliance with adding the relevant alerts to the patient's clinical records. There is a process to remove the flag if in 12 months no further incidents regarding the individual are referred to MARAC.

8.4 In 2021/2022 there was 826 MARAC cases, representing a 13.9% decrease compared to the previous year (the decrease may be part due to the previous year having lock down restrictions, which may have resulted in an increase in incidents of domestic abuse). This resulted in 2777 electronic patient records being reviewed, (Table 8) as each case requires the patient's and their significant others electronic patient record to be searched, in order that relevant and proportionate information is shared during the MARAC meeting.

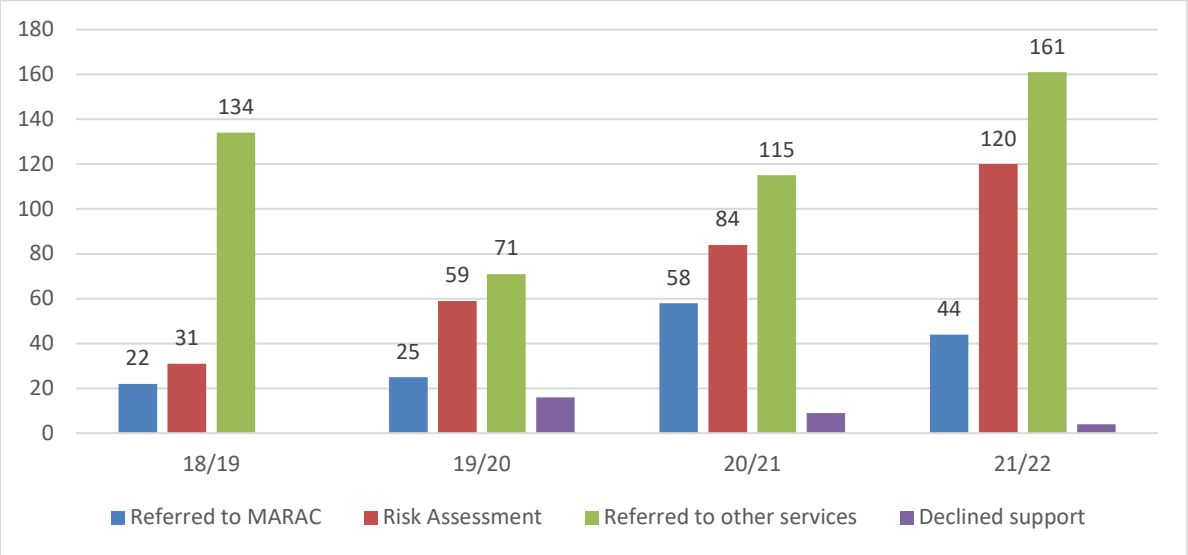
Table 8: **MARAC requests for information**



8.5 In incidents and or disclosure of actual or suspected domestic abuse, staff use the domestic abuse risk assessment to determine the most appropriate referral, (Table 9). This year has seen a 42.8% increase in the number of risk assessments completed. The referral to MARAC is undertaken by the safeguarding team, following a review of the datix and the risk assessment, and after the engagement of the person disclosing the abuse, and while there has been 24% decrease to MARAC, this year has seen a 40% increase in the number of referrals to other support services.

8.6 In the Domestic Abuse Needs Assessment in Sefton completed in 2021, the Trust were commended for being the highest referrer to MARAC second to the Police (the Police are expected to be the highest referrer).

Table 9: **Risk assessments and referrals to MARAC**

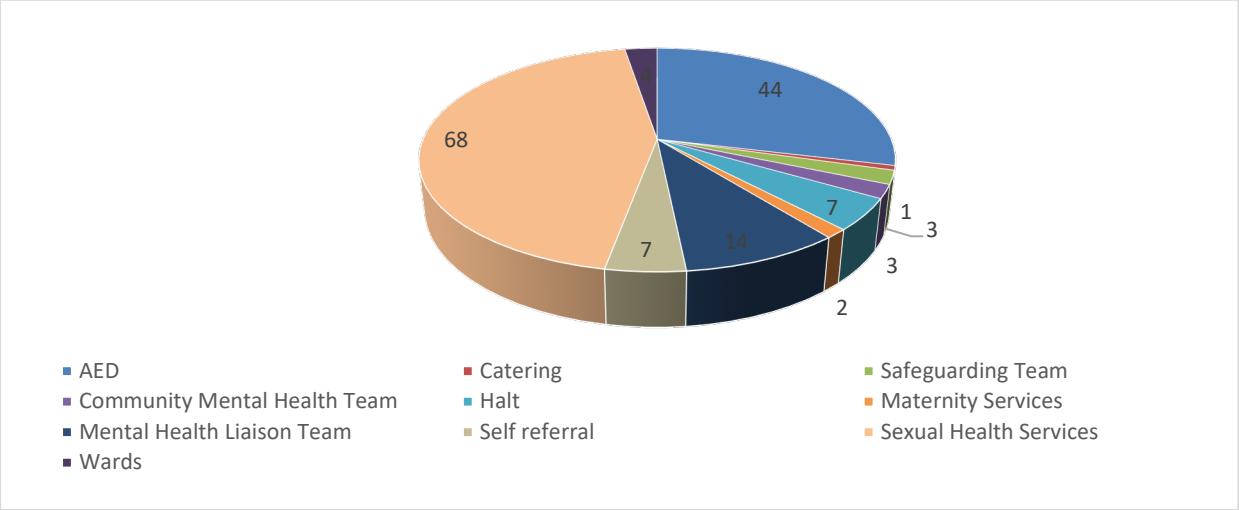


8.7 The safeguarding Team further provides support to a number of staff who are either the victim or the perpetrator of domestic abuse.

8.8 Health Independent Sexual Violence Adviser (ISVA)

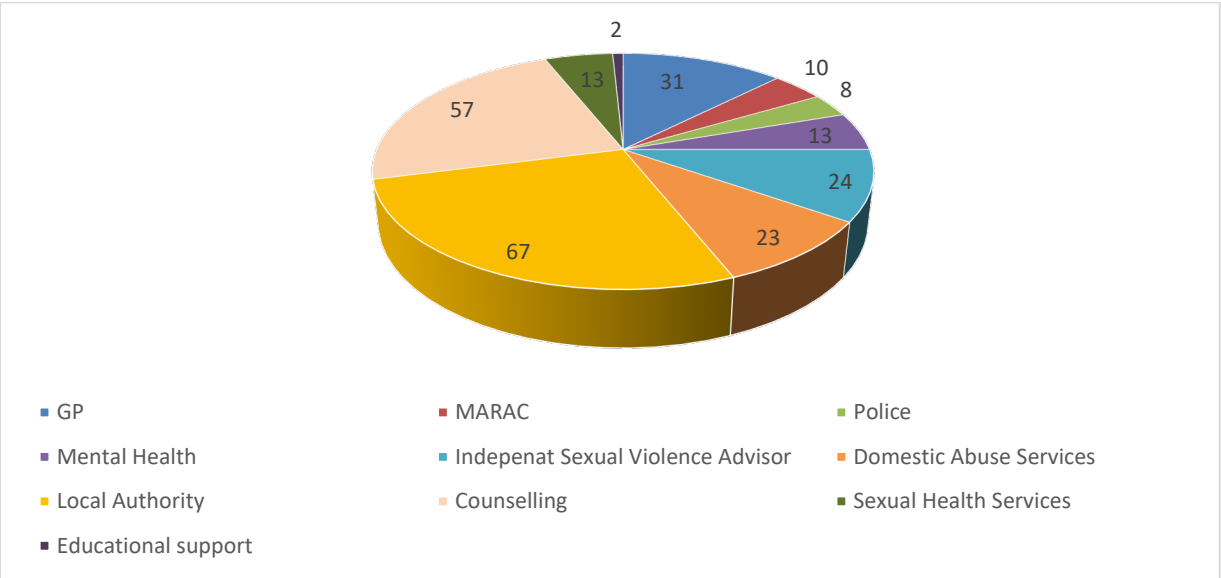
8.9 The Health Independent Sexual Violence Adviser (ISVA) is based within the safeguarding team. The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 159 referrals made from a range of sources, (Table 10).

Table 10: HISVA Referral Source



8.10 Between July 20221 to March 2022 the percentage of patients not open to any Sexual Abuse Services prior to HISVA engagement was 82%, and the percentage of patients who had experienced recent sexual abuse (in last 6 months) was 24%, with 74% experiencing non-recent sexual abuse.

Table 11: Referrals to Support Services



9.0 DOMESTIC HOMICIDE REVIEWS (DHR's)

9.1 The Trust is involved in four DHR's, which includes providing extensive chronologies (one dating back 25 years); undertaking individual management reports (IMR); providing Trust representation for all panel meetings.

9.2 The DHR's produce a final published report that the panel members approve, and the recommendations for each agency are included in report. To date the yet unpublished recommendations for the Trust include the provision of and Independent Domestic Violence Advisor (IDVA), ensuring routine enquiry at key moments, and staff undertaking professional curiosity.

10.0 SERIOUS CASE REVIEWS (SCR) and CHILD SAFEGUARDING PRACTICE REVIEWS (CSPRs)

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

10.2 A children's Safeguarding Practitioner is currently on the panel for 2 CSPRs, and whilst the Trust was not directly involved with the children, appropriate learning will be shared by the CSPR panel following the review. Following this the Safeguarding Team will identify any internal actions required.

10.3 This year the Trust has been required to provide information for rapid reviews in relation to 6 children which continued to a CSPR.

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

10.5 Learning from further CSPRs will be shared via the LSCB/CSAPs and the Learning and Development Subgroups, where the Trust provides representation.

10.6 SAR referrals are submitted to the LSAB, who triage and decide if to undertake a local panel to complete the SAR. The Named Nurse Adult is currently fulfilling the role of independent author for SARs 7 and 8, on behalf of the Merseyside SAB.

10.7 The Trust has not been required to provide information to support any SARs in 2021/2022

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

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

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

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

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

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

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

11.6 A spreadsheet is maintained detailing the expiry dates of the urgent and standard authorisations. This is enhanced by a DoLS proforma in Care Flow. The team sends an email regularly to the Supervisory Body, advising of patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the team is aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

11.7 This year has seen a 19.5% increase in the number of referrals for a DoLS authorisation to 1713, (Table 12).

- 1079 Sefton
- 622 West Lancashire
- 12 Other

11.8 Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who

have deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body, (Table 13).

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

Table 12: Deprivation of Liberty Safeguards Applications

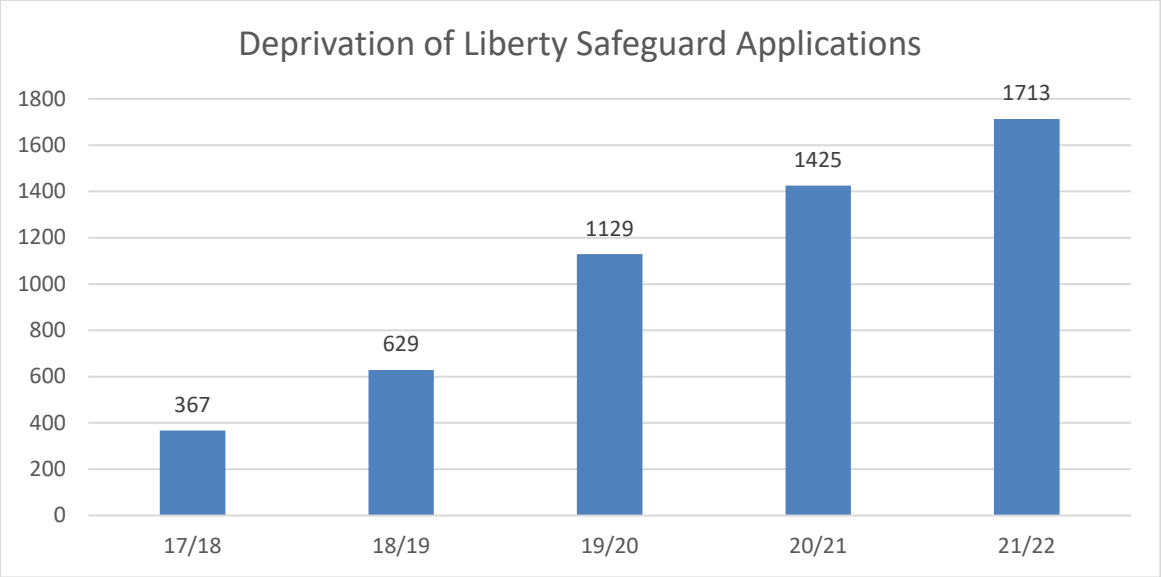
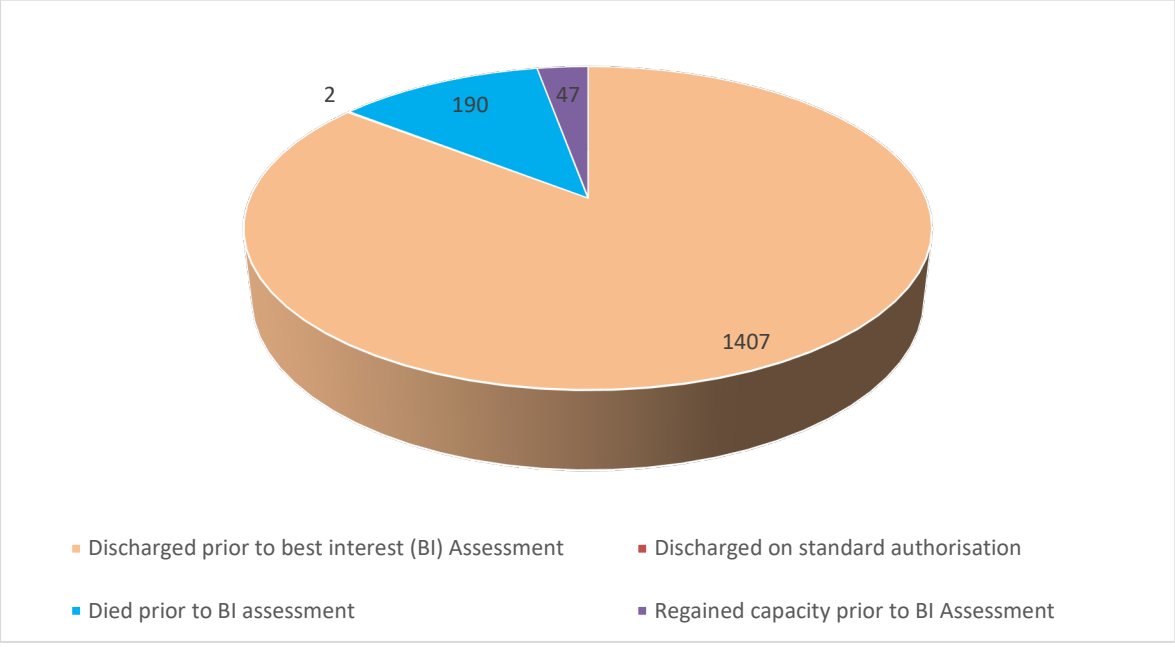


Table 13: Outcomes of DoLS Applications



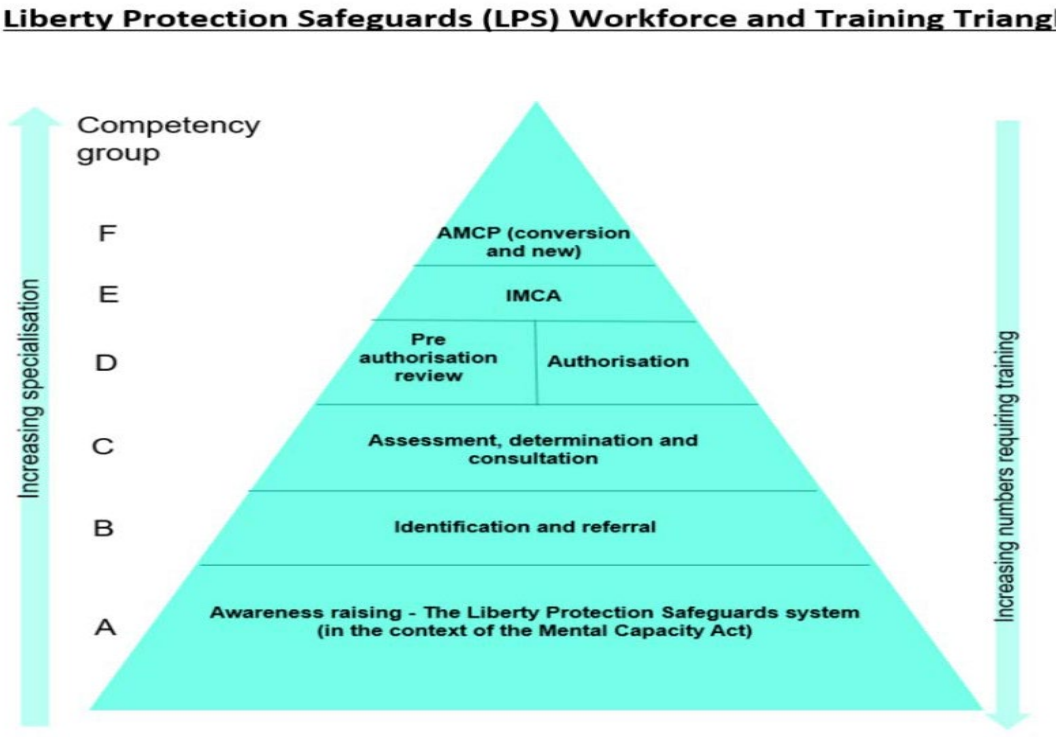
11.10 Liberty Protection Safeguards (LPS)

11.11 In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards, (although the term is not used in the Bill itself). The target date for implementation was spring 2020, later revised to October 2020, and due to the pandemic is expected to be October 2023.

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

- Include 16 years and above
- Deprivations of liberty to be authorised by the 'responsible body'. For NHS hospitals, the responsible body will be the 'hospital manager'.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks the capacity to consent to the care arrangements
    - The person has a mental disorder
    - The arrangements are necessary to prevent harm to the cared-for person and are proportionate to the likelihood and seriousness of that harm.

11.13 The LPS will have significant implications for acute NHS Trusts, as the authorisation of the LPS will be the responsibility of the hospital and not the LA, as in the current arrangements. It is unclear how the new LPS will affect the number of applications, as a result of the inclusion of 16- and 17-year-olds. NHS E/I have confirmed they will develop several training packages for the implementation of LPS, and a training hierarchy tree has been published. The training requirements will have a significant impact on the release of staff to undertake the training.



11.14 In March 2022 the Code of Practice was released for a 16-week public consultation. The Assistant Director of Safeguarding will provide either a single or multi-agency Trust response. The Code of Practice will inform partners to their statutory responsibility, and this will enable a mapping of the resources that will be required to fulfil these new statutory responsibilities. It is highly anticipated that a formal business case for additional staffing will be required.

12.0 LEARNING DISABILITY

12.1 The Royal College of Nursing (RCN) 'Connecting for Change Report' (2016 and 2021), recommend 'Every acute hospital should employ at least one Learning Disability Liaison Nurse, and by 2020/21 all acute hospitals should have 24-hour Learning Disability Liaison Nurse cover.'

12.2 In England there are approximately 1.2 million people with a learning disability who are known to social services and in receipt of services. It is estimated that this number is much higher when considering those with undiagnosed or a mild learning disability, who are not in receipt of services.

12.3 People with learning disabilities may experience multiple co-morbidities and chronic health problems. In the Confidential Inquiry (Heslop et al, 2013), 17% of the sample had four or more health conditions. Due to their experiences of both acute and chronic illness, people who are learning disabled have an increased attendance and admittance to acute general hospitals, and the demand from people with learning disabilities, their families and carers on specialist and general health service is expected to increase significantly in the future (Gates, 2011, as cited in Phillip, L. 2018).

12.4 The Learning Disability and Autism Practitioner commenced in the Trust in August 2021, being provided through NHSP, with this cost being offset using a vacancy factor within the Safeguarding Team. Since commencing in August the post has demonstrated extensive value in relation to patient and care experience and providing staff support. In this time the current post-holder has shown the value of developing relationships with the patient's family, and or carers, and maintaining daily/weekly communications with the family. This has resulted in freeing the time of the ward-based nurses in conversations that can often be emotional and lengthy, and requiring a deeper level of experience and understanding of the needs of a patient with a learning disability and or autism.

12.5 In December 2021 the Learning Disability and Autism Practitioner accompanied two patients to theatre during a surgical procedure, staying with the patient through the anaesthesia, procedure, and recovery period. The practitioner has organised and or participated in a significant number of multi-disciplinary, and or best-interest meeting, providing an expert level of knowledge, acting as the patient's advocate, and thus enabled informed decision making.

12.6 The Learning Disability and Autism Practitioner has provided an extensive amount of support to ward staff; supporting ward-based care; the provision of reasonable adjustments; facilitating a timelier discharge; providing ad-hoc learning disability and autism awareness sessions. They have established strong communications with community-based learning disability services, ensuring a collaborative approach to meeting the patient's care needs.

12.7 The Learning Disability and Autism Practitioner has developed training material and secured funding for the 'Autism Bus Experience' to be provided at the Trust on 6 occasions during 2022. Further ad-hoc training is being provided to clinical teams, as requested. The Practitioner has further obtained funding for communications aids and is developing the Trusts local policies and documentation.

12.8 The number of patients with a learning disability alert on their record has increased by 58% from the last NHS E/I submission compared to the number of patients with an alert in February 2022. This is largely due to these being added since August 2021, when the practitioner in post has actively sort to add the alerts. This will further have financial implications due to more accurate coding relating to the in-patient and out-patient activity for patients with a learning disability.

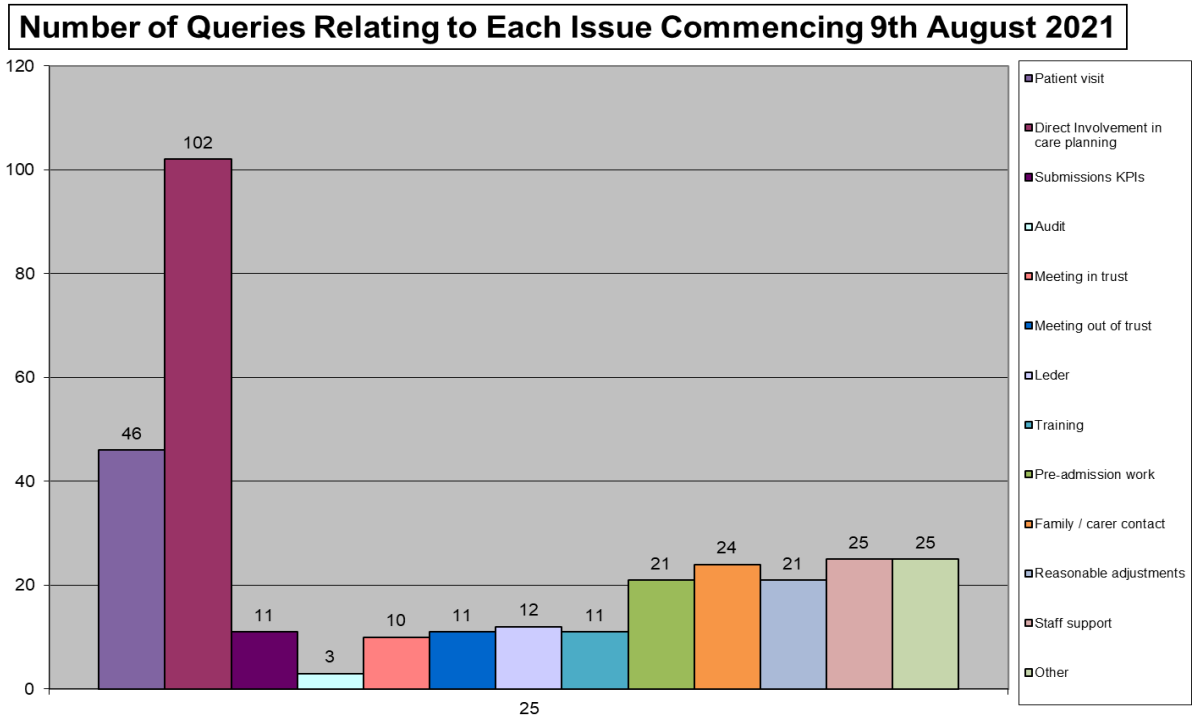
12.9 The Learning Disability and or Autism Practitioner supports the Learning from lives and deaths – People with a learning disability and autistic people **(LeDeR)** agenda, ensuring the Trust reports within the required timeframe the deaths of those with and learning disability and or autism. The Learning Disability and or Autism Practitioner liaises with the LeDer reviewer to provide the required information and following the review feedback recommendations into the Trust Mortality Operational Group. The Learning Disability and or Autism Practitioner provides representation at both Lancashire and Sefton LeDeR steering groups, ensuring the Trust is sited on improvements required to improve the lives, and prevent unavoidable deaths of those with a learning disability and or autism. The Assistant Director Safeguarding provides Trust representation at the LEDER review panel meetings for Sefton.

12.10 The annual NHS E/I submission learning disability and autism benchmark was completed and submitted in March, within the required timeframe, and the Trust are awaiting the results.

12.11 The Learning Disability and Autism Practitioner represents the Trust at the SEND Improvement Programme Meeting and has established links with the SEND Lead.

12.12 Table 14 below represents some of the activity captured in the past 6 months. The table is not an exact representation, as not all activity has been documented. The information is further based on the part-time hours of the Learning Disability and Autism Practitioner, and therefore the activity would be even higher if the post covered a 5- or 7-day working week.

Table 14 Learning Disability and Autism Activity



12.10 Feedback

Dear Sir or Madam,
may I take this opportunity to thank whoever is responsible for creating the input of extra care for people like my son xxx, dob xxx, whilst so frequently in hospital. Xxx unfortunately, has had to be in and out of Southport hospital since he was 6 years old due to his uncontrollable Epilepsy (Lennox Gastaut Syndrome). There were times when I wished there was someone there at the hospital to stand up for xxx and alongside me for one thing or another. Then along came Emma Houghton.!
Emma has been so helpful and it's so good to have that level of support whilst xxx is in Hospital, he is in Ward 11b now.
Don't worry if we EVER win the lottery Southport Hospital will be right at the top of our list. 😍😍😍
Thank you.
WARMEST REGARDS.
XXX

Morning Emma

I am writing to express my sincere thanks for your support recently when my daughter, xxx, came into Southport DGH for an operation. Xxx has very complex needs and her having an operation is one of the most challenging things we've had to navigate. Your support was invaluable from the very start of this process right up until very point Xxx came round from the operation and beyond. My family and I wanted to thank you for this thorough and empathetic support and would ask that you forward this email to your managers please?

With very sincere thanks

xxx

13.0 PREVENT

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

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

Table 15: Prevent Training Compliance

Overall Trust Compliance	Oct	Nov	Dec	Jan	Feb	March
PREVENT Level 1 and 2	95.4%	96.2%	95.6%	95.4%	95.6%	94.5%
PREVENT Level 3 and 5	88.9%	88.1%	88.9%	90.0%	90.4%	89.4%

13.3 The Trust has made no PREVENT referrals this year.

14.0 MANAGING ALLEGATIONS

14.1 There have been 22 reports that led to consideration for evoking the allegation policy. This is a 69% increase from the previous year, which may in part be a result of the revised policy and improved compliance to the policy.

In all cases the CBUs have taken responsibility for responding to the allegation raised and undertaken the required strategy meetings for an informed decision in managing the allegation.

15.0 SAFEGUARDING AUDITS

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

Completion of safeguarding documentation for adults attending Adult AED
Use of the under 18 AED card
Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm (19-003)
The quality of children's social care referrals from Paediatrics, Maternity and adult AED referrals

Quality of child protection medicals
Maternity Did not Attend compliance
The quality of adults safeguarding referrals
The quality of domestic abuse referrals
The completion of MCA and DoLS documentation

Quality of adult referrals audit.
This audit offered significant assurance, which has seen improvement from previous audits. It is apparent that staff are still not providing details of the dependants. This is mitigated as the referral to the online Local Authority portal is completed by the safeguarding team who will undertake an advanced search to identify dependants and provide this information. The referral form is being built within datix, therefore moving forward some fields will be made mandated.

Quality of Children's referrals audit.
This audit has offered significant assurance. Again, the area of reduced assurance is mitigated as the safeguarding team quality assure all referrals and if required provided additional information to the Local Authority.

Child Protection Medical Audit
The assurance level is significant for this audit. This is a clear improvement on the original audit and indicates that the recommendations and additional training and discussions around the importance of the process has been beneficial.

MCA knowledge transfer audit.
This is audited as part of the Trust Southport and Ormskirk Clinical Assessment and Accreditation Scheme SOCAAS and this year the question set in the audit was changed. The knowledge audit is demonstrating staff have an underpinning knowledge of MCA and safeguarding. Some improvements can be made in the completion of the DoLS authorisation, but as all DoLS authorisations are quality assured before submitting to the LA this is mitigated.

Paediatric Accident and Emergency (PAED) Documentation Audit
This audit offered significant assurance. Currently the AED card in the department is being revised.

AED Documentation compliance audits
These two audits are essentially documentation audits, to demonstrate if staff are completing the safeguarding question set on their documentation. Regarding the adult AED documentation audit, the audit offers assurance that improvements have been made given that the overall audit score is 74% as opposed to the one completed in Q2 which had an overall score of 21.7%. However, the <18 CAS card audit has shown a decrease in the use of this document. The audits are shared with the ADo for CBU and the Lead Nurse to identify actions to be taken to improve compliance further.

Maternity Did Not Attend SOP Compliance Audit
This audit has offered full assurance that Midwives are following the revised SOP.

Adults at Risk of Deliberate Self-harm Audit

This audit reviewed a cohort of 20 patients at risk of deliberate self-harm to identify if there is documented evidence of safeguarding routine enquiry, including domestic abuse, sexual abuse, and dependants. The audit offered limited assurance regarding documented evidence.

Quality of Domestic Abuse Referrals Audit

This audit is essentially an audit of completed domestic abuse risks assessments. The audit provided limited assurance due to lack of completed details regarding the children, such as address, and a safe number not being documented on the risk assessment. The mitigation is that all referrals of domestic abuse are checked by the safeguarding team. As a result, the children's information is provided to the Local Authority, and while the safe number was not documented on the risk assessments it was documented elsewhere in the patient's clinical record.

16.0 COMMISSIONING STANDARDS

16.1 The Trust submits a quarterly update to South Sefton CCG as part of the KPI submission. The requirement has been for an updated commissioning standards action plan to be submitted each quarter, to demonstrate progress against the action plan developed against the previous self-assessment.

In Q4 all actions on the action plan were completed and submitted with the Q4 KPI return.

Comm Standards Action plan

17.0 RISK REGISTER

18.1 There are 2 risks relating to safeguarding in 2021/22:

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

18.2 The Trust currently does not have a clinical photography team; as a result, photographs provided by the Trust for the purpose of child protection and criminal investigation processes and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. The Assistant Director of Safeguarding is to explore the possibility of this service being a joint venture with St.Helens and Knowsley.

18.3 An additional risk that may require adding to the risk register in 2022/23 and will only be determined on the publication of the final LPS Code of Practice.

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

18.0 THE SAFEGUARDING TEAM's WORK PLAN 2022/2023

- We will complete the LPS Code of Practice feedback
- We will plan and prepare in preparation for the implementation of the LPS process, ensuring the Trust meets it statutory obligations
- We will develop and present a business case for the implementation of LPS as required
- We will present a business case for a substantive Learning Disability and Autism Practitioner
- We will recruit to the Learning Disability and Autism Practitioner Post if the business case successful
- We will develop the workforce to care for patients with a learning disability and or autism
- We will make improvement to ensure the Trust is complaint with Learning Disability Improvement Standards by 2023/24.
- We will apply for all available external funding for an IDVA
- We will recruit to an IDVA should funding be successful
- We will work with IT colleagues to develop and implement digital streamlined process
- We will achieve adherence to the S42 Memorandum of Understanding
- We will continue to improve the completion of the safeguarding documentation in AED
- We will continue to ensure the development of a network of safeguarding ambassadors
- We will seek to maintain training compliance ensuring compliance to the intercollegiate documents
- We will review the implementation of the 'graded care profile tool for antenatal care' if it is launched by Local Authority to deem if appropriate for the Trust.
- We will support the Sefton partnership with the subsequent action plan following the publication of the Ofsted visit
- We will continue to facilitate training for the partnership via the training pool
- We will continue to support with relaunch of CFWS (Lancashire) and Early help offer (Sefton)
- We will work with the Mental Health Act Administration team to ensure patients are detained at the Trust under the correct legal framework
- We will seek to ensure staff are empowered to care for 16- and 17-year-old in an adult setting
- We will implement more drop-in and supervision safeguarding children's sessions
- We will develop databases to identify relevant trends and themes.
- We will be a member of a review group in Sefton looking at the MASH referral form.
- We will become a member of a steering group in Lancashire, along with representative from maternity management looking at developing best practice guidelines for babies born into care
- We will review the Termination of Pregnancy procedures following the publication of a CSPR
- We will support Sefton Local Authority in the review of their referral processes

19.0 CONCLUSION

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

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

20.0 RECOMMENDATIONS

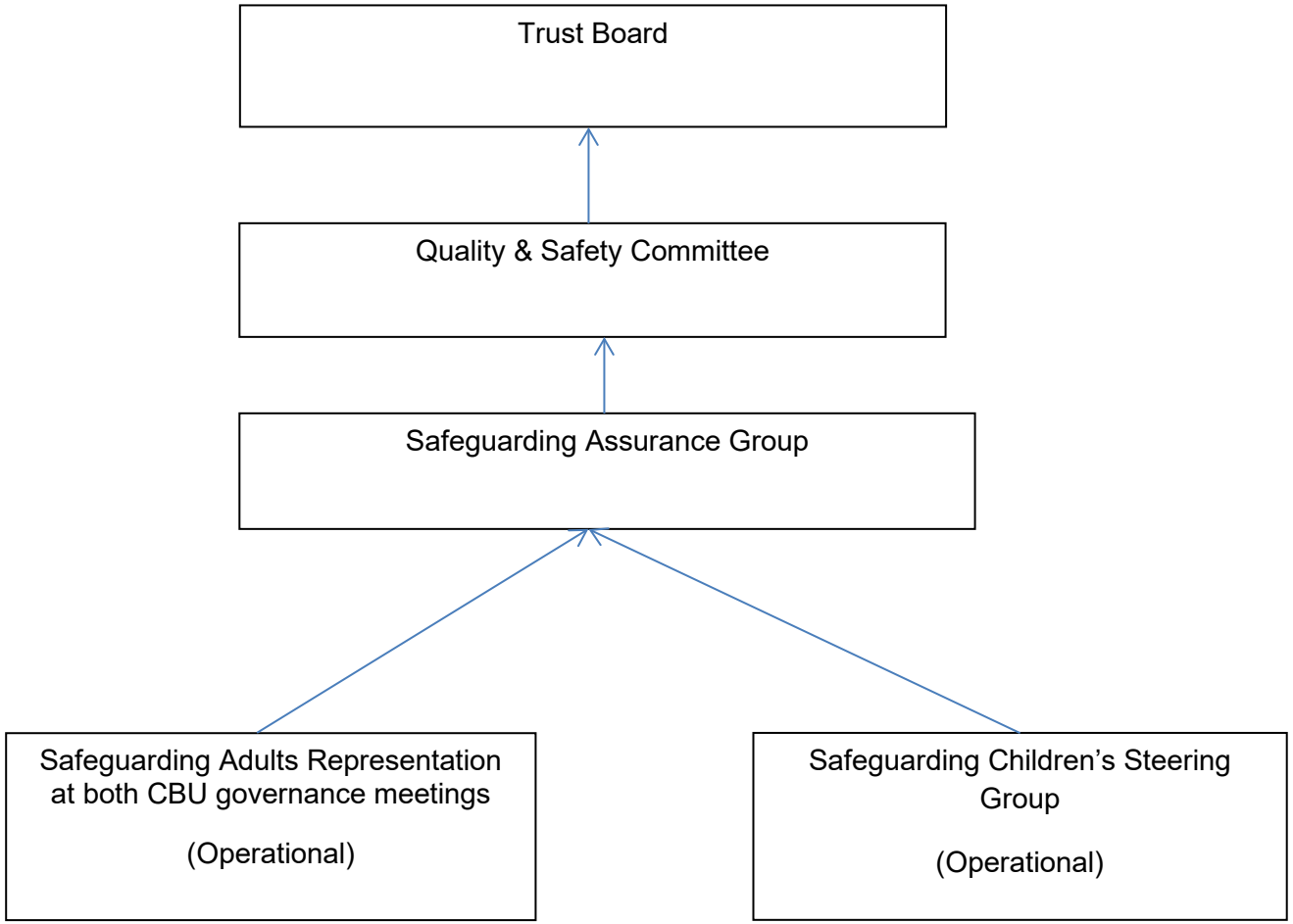
21.1 The Board is asked to recognise the achievements made by the Safeguarding Team this year outlined in the report and agree the work plan for the year ahead.

21.0 CASE STUDIES

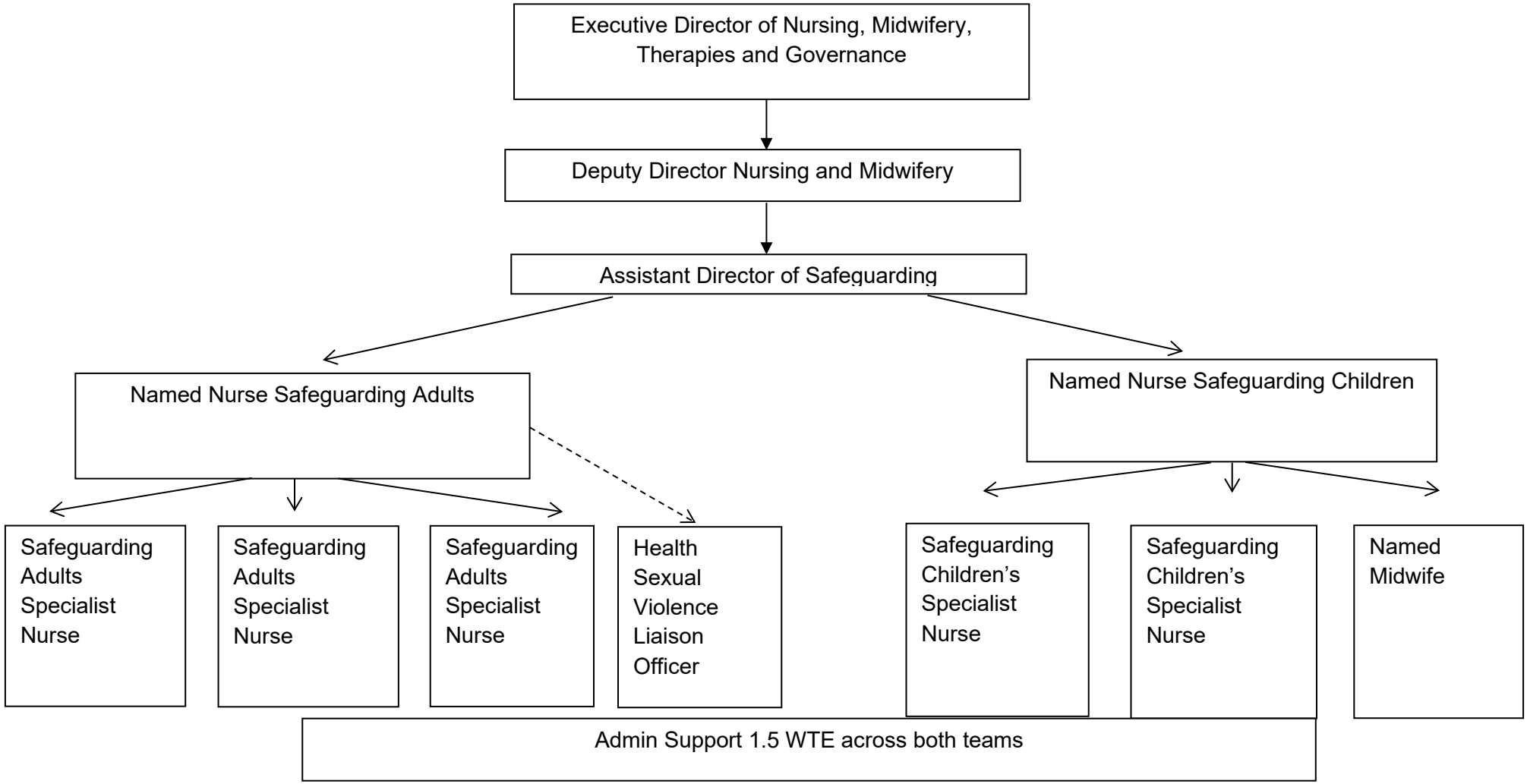
22.1 The 5 case studies below provide examples of the role of the safeguarding team and value in safeguarding the un-born children, young people and adults at risk of abuse. In all names have been changed.

(The below case studies have been removed due to the nature of content)

Appendix 1: Governance Arrangements



Appendix 2: Southport and Ormskirk Trust Safeguarding Structure



Notes

Section	Comments

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**06 July 2022**
Agenda Item	**SO131/22**	**FOI Exempt**	**NO**
Report Title	**ANNUAL INTEGRATED GOVERNANCE SAFETY REPORT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Brendan Prescott. Deputy Director of Quality, Risk and Assurance		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

This Annual report provides an overview of integrated governance performance throughout 2021/22.

Executive Summary

Assurances

All data provided in this report has been taken for 2021/22 and the first two months in 2022 Q1 to provide a better overview of our overall position.

Incidents:

- The report provides a good level of assurance with regards to a positive incident reporting culture.
- There was 1 'Never Event' reported in the reporting period of 2021/22 which has been included in the data for this report.
- There continues to be validation of waiting lists and review of associated harm for patients with treatment delays. Lost to follow up incidents are being monitored within the CBUs and reported into the Clinical Effectiveness Committee for assurance.
- There is a robust process in place to ensure that serious incidents are reported on StEIS within the required time period as set out in the NHS Serious Incident Framework. Furthermore, the report shows good compliance with investigation timescales supporting a commitment to meeting internal and external performance measures.
- The report identifies system learning that has arisen from incident and complaint investigation.
- The Trust can provide good assurance with regards to compliance with statutory Duty of Candour requirements; performance remains 100% compliant.
- A Scrutiny and Assurance Group has been established to monitor actions arising from Incidents, Complaints, Risk and CQC Concerns.
- A new Incident Management Framework (IMF) has been designed and is currently going through approval process to be implemented in the Trust.
- A Human Factors Introduction training programme has been launched within the Trust led by the Assistant Director of Integrated Governance (ADOIG). This training programme is monitored by a course survey and in the reduction of Human Factor related incidents. The Trust has recently been nominated for a HSJ (Health Services Journal) award in Human Factors.

Complaints:

- The most common complaints subjects were in Accident and Emergency, however a recent appointment to add a PALS officer into the area is supporting the Trust in making improvements in this area.

- Lessons learnt are being reviewed and are regularly discussed in CBU governance meetings and the Trust's Patient Experience meeting.

Risk Management:

- During 2021/22 there was a drive from Q2 onwards to engage the Business Units in the risk management process. The Risk Registers and processes continue to be reviewed by the Assistant Director of Integrated Governance (ADOIG).
- The ADOIG also provided Risk Management Training which is continuing throughout 2022. Surveys completed by those been trained so far have shown a significant increase in risk management knowledge and quality of risk description and management has improved with fewer risk reviews overdue on a monthly basis with an 11% average overdue for the last 3 months.
- The ADOIG has recently launched the Trust's new Risk Management Framework (RMF) which supports the quality improvement and development of risk management in the Trust, associated training is also being rolled out in the Trust to support this.
- There has been an improvement in action management since Q3 2021/22 and this continues to remain positive.
- An improved RCG (Risk and Compliance Group) has been launched to support the assurance and the management of risk throughout the Trust, improving the quality of risk updates.

Claims & Inquest Management:

- Claims and Inquest management has improved with a significant number of legacy claims now closed due to dormancy, however there are inquests being set for 2022 which are now being picked up by the Claims and Inquest Manager.
- Improved stability has been provided into the team with the appointment of an administrator and work is ongoing to improve the reporting, collation of data and the retrieval of records for claims and inquests.
- There have been 33 inquest cases listed with the coroner over the last 12 months.
- 1 case resulted in the Trust receiving a regulation 28 (Prevention of future deaths report).

Action Management:

- Whilst there are mechanisms in place to identify and monitor overdue incident and complaint actions, there continue to be significant delays in closing actions. The newly established Scrutiny and Assurance group will manage this through its terms of reference and monitor performance of action monitoring and management.

Lessons Learnt:

- The Trust received Moderate Assurance in 2021/22 for a Lessons Learnt audit which was undertaken by MIAA within Incidents and Complaints. There are still actions to undertake to ensure that lessons and learning from incidents and complaints is reflected well across the Trust, including the need to update existing policies.
- Further work has been completed during 21/22 to improve lessons learnt being communicated and embedded into the Trust with the establishment of the Scrutiny and Assurance group and the updated Terms of Reference for the Harm Free Care panel.

Training and Performance:

- There needs to be a review of internal systems and processes to support incident handlers in managing incidents within the stipulated timeframes.

- Integrated Governance training continues across the Trust with the IG team regularly supporting the CBUs in the delivery of this training and ensuring colleagues have the right tools to enhance governance practice across the teams.
- Human Factors training launched in Q1 22. This was initially focussed at Women's and Children's colleagues and has now branched out further across the Trust supporting all colleagues with Human Factors Introduction.
- Risk Management training across all CBUs continues to run monthly with a positive attendance and feedback which is collected through regular survey management of the course.
- The Trust Patient Safety Specialists (PSSs) have been meeting regularly to ensure the Trust is Patient Safety Incident Response Framework (PSIRF) ready for launch in 2022. The PSSs have ensured that training, guidance and support is available and ready for colleagues when the national mandated change to the Incident Management Process is launched.

Recommendations

The Strategy and Operations Committee is asked to note the Annual Integrated Governance Safety Report for 2021/22.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **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

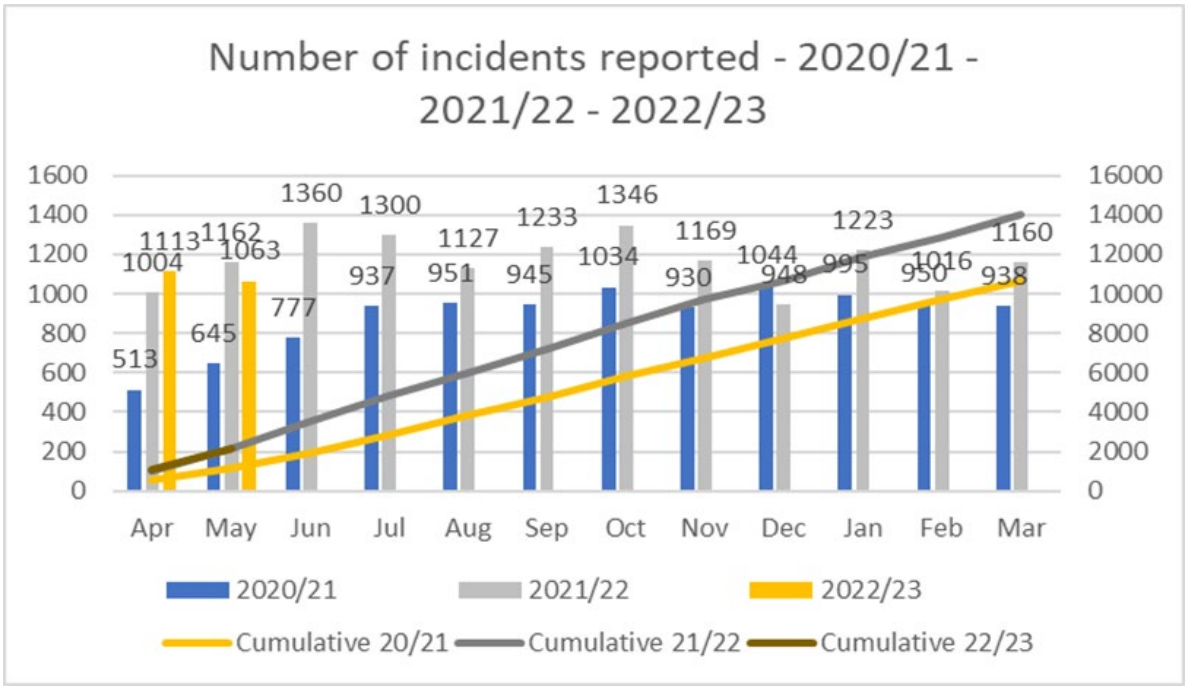
Prepared By:	**Presented By:**
Matt Stephen, Assistant Director of Integrated Governance	Brendan Prescott, Deputy Director of Quality, Risk and Assurance

Contents

1. INCIDENT MANAGEMENT

1.1. Incidents Reported

Figure 1 below shows the number of incidents reported (excluding external incidents), Month by Month for 2021/22, compared to the previous financial year 2020/21, and current financial year to date (2022/23).



Assurance **–** The data reflects the Trust continues to develop a good reporting culture and that reporting systems are functioning as expected. Overall for 2021-22 there was an increase in overall incident reporting of 32% compared to the previous year. A review of incidents and themes have shown :

- An increase in Lost to follow up incidents logged due to the validation process in place in the CBUs to capture this information.
- An increase in incidents due to COVID-19 infection / exposure of both staff & patients.
- A heightened reporting culture due to increased activity around Integrated Governance training.

1.2. Never Events

There were no Never Events reported for the year 2021-22. 1 Never event was reported in month 1 2022-23.

ID	Reported	Business Unit	Ward / Dept	Category	Sub category	Severity	Description
108997	30/04/2022	Planned Care	HDU	Surgery related Incidents	Retained foreign object post-operation (NEVER EVENT)	Low harm - minimal harm patient required extra observation or minor treatment	Patient required a central venous line and VAS Catheter inserting in a critically ill patient. Dr had scanned the patient's neck (right IJ) and located vessel and had set up correctly following aseptic procedure. Trolley had been set up for both VAS Catheter and CVC line insertion as both were going in the same area. On inserting the CVC line, Dr had asked whilst still in his gown and sterile that he could not find the guide wire (there had been three and now he had two) and he asked staff members to have a look to locate it. The Dr then checked on the scanner and located it in the patient.

The Never Event was presented to Serious Incident Review Group following notification to NHS England and input to StEIS in April with identification of immediate actions to mitigate the risk of incident reoccurrence.

1.3. Incidents by Level of Harm

The table below shows a breakdown of incidents reported April 21 – May 22 by level of harm and type of incident.

Assurance- High reliability organisations are those with a good reporting culture where there are high numbers of incident reporting but with low levels of harm. The Trust has reported 0.6% of overall incidents as moderate and above harm levels, the rest are low harm and below incidents. The percentage level for 2021-22 is comparable to the previous year.

All incidents reported April 2021 – May 22

	Near Miss	No harm caused	Low harm - minimal harm patient required extra observation or minor	Moderate short term harm need further treatment / procedure	Severe harm - permanent or long term	Death as a direct consequence of the incident	Death - Unrelated	Grand Total
Patient Affected (Related to a Patient)	185	12053	1215	51	11	6	61	13582
No-one directly affected	113	902	278	25	3	2	1	1324
Staff Affected	158	1068	36	1				1263
Visitors, Contractors or Public Affected	8	38	8	1				55
Grand Total	464	14061	1537	78	14	8	62	16224

In 2021-22 there was a total of 51 moderate harm incidents, 11 severe harm incidents and 6 deaths across all clinical areas. Medicine and Emergency Care reported the majority of moderate harms and above which is as expected given the breakdown of patient activity across the Trust. 61 in total.

1.4. Staff Incidents

Incidents involving staff across all clinical areas are detailed blow with the majority of incidents recorded being low harm. The top 5 Categories of incidents were physical abuse / violence patient on staff; needlestick injury ; covid 19 infection; insufficient nurses/ midwives and collision with an object or person.

Level of harm	Total number
Low harm - minimal harm patient required extra observation or minor treatment	278
Moderate short-term harm need further treatment / procedure	25
Severe harm - permanent or long term	3
Death as a direct consequence of the incident	2

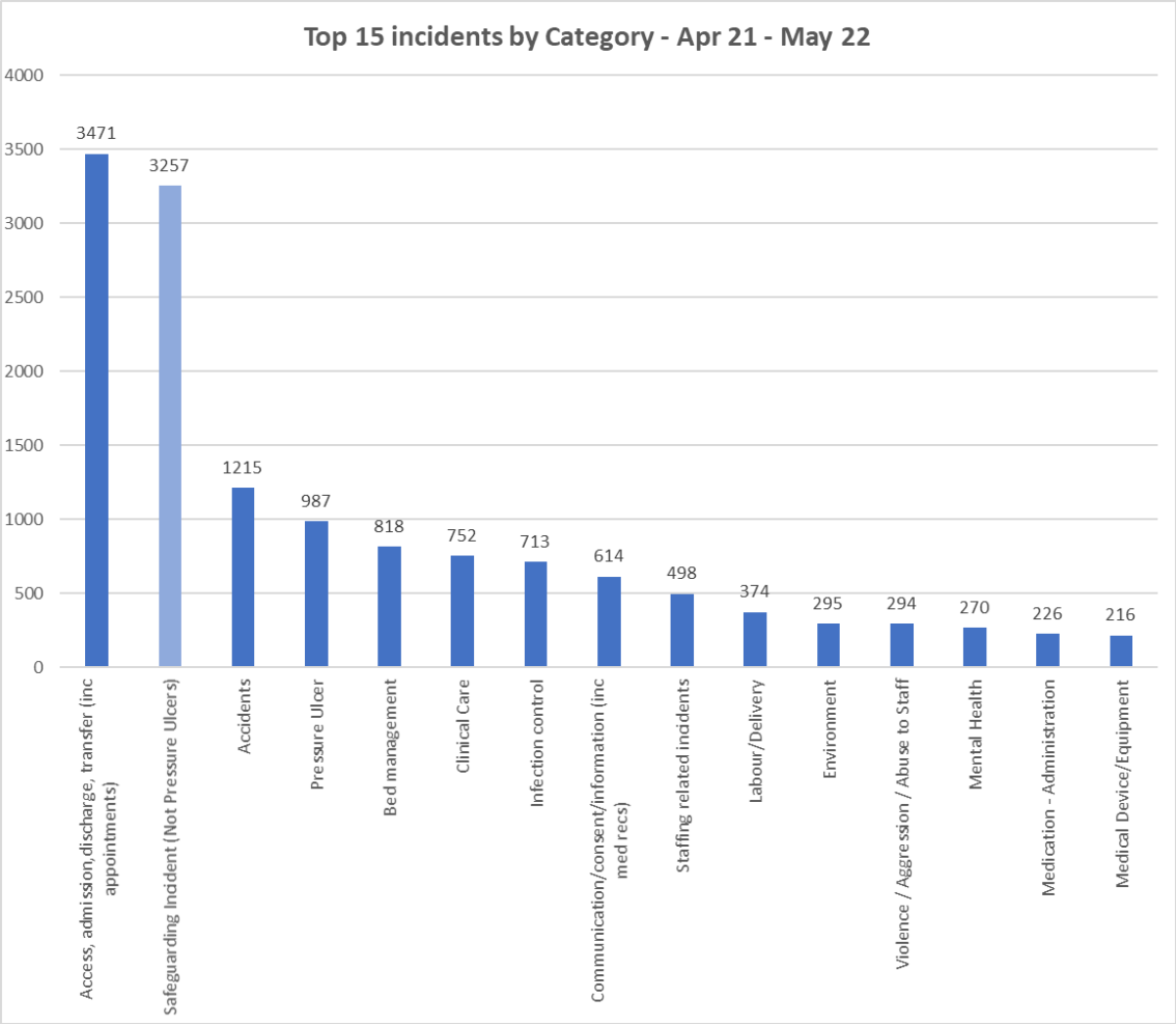
The 3 cases of severe harm related to 1 member of staff contracting Covid 19 ; 1 member of staff's reaction to the Covid 19 vaccination and 1 member of staff subjected to a physical assault. All three cases were investigated through the SIRG process, reported externally in the case of vaccination and all cases reported to StEIS. The staff assault was also subject to a police investigation.

The 2 deaths were both related to staff who contracted Covid 19 whilst employed by the Trust and have undergone investigation with Health and Safety support with external submission to the Health and Safety Executive. The Trust is waiting to see if

there is any further action resulting in the submission to the Health and Safety Executive.

1.5. Incidents by Category

The chart below shows a breakdown of the top 15 incidents reported in 2021/22 by Category:



- The highest category was access, admissions, discharges, transfer (Inc. appointments) with 2373 incidents out of the 3471 reported, pertaining to patients lost to follow up from outpatient clinic streams as per on-going workstream set up to manage these.

Assurance –There continues to be strong evidence to support discussion at local governance meetings and recognition of associated risks on risk registers. There continues to be validation of waiting lists and review of associated harm for those patients with treatment delays. The strength of actions and assurances will need to be monitored in line with the Trust risk management process and should inform interventions and future improvements. The Trust is also implementing an enhanced process for clinical harm review.

- The second highest category was Safeguarding Incidents: These incidents are reported internally but do not represent acts or omissions by the Trust.

Assurance – The Trust Incident Management System (Datix) is used to record events that require appropriate action to be taken by parties outside of the organisation e.g. a referral to the Local Authority for self-neglect or police fro domestic violence. High reporting in this category demonstrates a good awareness of issues such as Safeguarding and DOLs applications for vulnerable patients , etc by staff across the Trust.

- The third highest category of incidents reported was 'Accidents'. This category captures inpatient falls but as previously mentioned represent a large number of No and Low Harm incidents.

Assurance **–** The Deputy Director of Quality, Risk and Assurance has introduced a thematic review of falls related incidents that will enable focussed discussion at the Falls Improvement Group. The Trust also appointed a Trust Falls Lead in Q4 2021-22 to lead on the falls workstreams.

1.6. Incidents by Area Related to the Covid-19 Pandemic

	2021									2022					Grand
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Urgent Care	89	26	51	47	17	36	20	23	21	97	26	19	15	14	501
Planned Care	7	12	10	18	2	7	22	10	24	35	11	28	19	5	210
Women & Children's		7	14	12	15	6	3	11	3	18	7	3	5	1	105
Estates & Facilities		1	1	3	6	5		4	14	31	2	10	9	1	87
Clinical Support Services									19	12	3	14	1		49
Integrated Governance & Quality	2				1		2	1	3			1			10
Non Trust Location	1	1		2						5					9
Medical Director	2	1	1											1	5
Executive Management						1	2			1					4
Finance							1			2					3
Performance Division		1								1	1				3
Human Resources							1			1					2
Corporate Governance										1					1
Grand Total	101	49	77	82	41	55	51	49	84	204	50	75	49	22	989

The vast majority of incidents related to Covid-19 are on the positive diagnosis of patients following testing during the inpatient stay during 2021-22. Testing was and continues to be carried out patients on days 0, 3 and 5 and every 5 days after this point of the inpatient stay.

1.7. Incident Timescales (No, Low Harm and Near Misses)

The table below shows the adherence to timescales as set out in the Trust's Incident Management Policy. The inability to adhere to these timescales can impact on the Trust's ability to report to the National Reporting and Learning System (NRLS) by the required deadlines and could affect the Trust's incident reporting data.

Incident Timescales	Target	Q1 2021/22		Q2 2021/22		Q3 2021/22		Q4 2021/22		Q1 - 2022/23 - To date	
		Actual Performance	% Incidents Achieving Target Timescales	Actual Performance	% Incidents Achieving Target Timescales	Actual Performance	% Incidents Achieving Target Timescales	Actual Performance	% Incidents Achieving Target Timescales	Actual Performance	% Incidents Achieving Target Timescales
Time between Incident Knowledge and Date Reported	1 day	3	49.18%	2	45.49%	2	90.19%	3	47.51%	3	40.76%
Initial review of the incident	5 days	3	96.60%	2	97.54%	1	97.97%	3	96.26%	3	93.43%
Complete and close the incident (based on all incidents closed in Quarter, excluding StEIS & Moderate Harm RCA incidents)	5 days from date of review	33	57.48%	27	55.25%	26	52.48%	19	66.10%	18	63.61%

Assurance – The above identifies good compliance and the commitment of staff to report incidents in a timely manner. There has been an improvement seen in achieving these targets since Q4. Data supports there are robust systems in place to ensure all incidents receive review within 24 hrs of being reported (inside of normal working hours). It remains the case that there needs to be improvements seen with regards to the processing of No and Low Harm incidents once a handler has been identified. This activity is highlighted within the monthly PIDA reports and is also monitored by the Integrated Governance Team.

Recommendation – There needs to be a review of internal systems and processes to support incident handlers in managing incidents within the stipulated timeframes. This will be addressed by the further implementation of associated Incident Management Training to be rolled out alongside the launch of the Incident Management Framework in Q1/Q2 2022-23.

1.8. Incident Timescales (Internal RCAs)

No of internal RCA's - Overdue at end of QTR					
CBU	QTR 1 - 2021/22	QTR 2 - 2021/22	QTR 3 - 2021/22	QTR 4 - 2021/22	QTR 1 - 2022/23 To date
Urgent Care	9	1	1	0	0
Planned Care	5	7	4	6	2
Women & Children's	1	2	1	0	0
Grand Total	15	10	6	6	2

Assurance – There are clear processes in place to monitor performance against internal measures. Though there are some delays seen there is recognition of the challenges in the organisation on staffing availability to complete investigations and how these impact on performance. However, the performance continues to improve in 2022-23 with less overdue RCAs after internal changes to our governance processes.

1.9. Duty of Candour

The Trust is able to provide good assurance with regards to compliance with statutory Duty of Candour requirements; performance remains 100% compliant. This supports the view there are robust systems and processes in place and there is a strong commitment to openness and transparency within the Organisation with regards to incident management.

1.10. Strategic Executive Information System (StEIS) Reportable Incidents

The table below shows the Serious Incidents that were reported on StEIS during the reporting period (Apr 21 – May 22).

In 2020/21 the Trust reported 24 incidents to StEIS, compared to 23 in 2021/22.

Incident	Business Unit	Ward / Dept	Severity	Investigation within 60 days as per policy	Investigation stage
Patient Fall	Planned Care	General Surgery - Colorectal (11A)	Death as a direct consequence of the incident	Yes, Extension agreed	Completed - Submitted to CCG 28/07/2021
Anticoagulation delay	Planned Care	Ward 14A	Death as a direct consequence of the incident	Yes	Completed - Submitted to CCG - 23/02/2022
Central line retained	Planned Care	HDU	Low harm - minimal harm patient required extra observation or minor treatment	Yes	Investigation underway - Due at CCG - 27/07/2022
Patient Fall	MEC	Ward 7A	Severe harm - permanent or long term	Yes	Completed - submitted to CCG 08/09/2021
Patient Fall	MEC	FESS	Severe harm - permanent or long term	Yes	Completed - submitted to CCG 23/09/2021
Patient Fall	MEC	Clinical Decision Unit	Severe harm - permanent or long term	Yes - Extension agreed	Completed - submitted to CCG 24/11/2021
Aspiration	MEC	FESS	Death as a direct consequence of the incident	Yes	Completed - submitted to CCG 22/11/2021
Patient Fall	MEC	FESS	Severe harm - permanent or long term	Yes	Completed - Submitted to CCG 16/02/2022
Assault, patient on patient	MEC	Ward 7A	Low harm - minimal harm patient required extra observation or minor treatment	Yes - Agreed extension	Investigation underway - Due at CCG - 21/06/2022

Patient Fall	Urgent Care	Short Stay Unit	Severe harm - permanent or long term	Yes	Completed - submitted to CCG 14/04/2022
Patient Fall	Urgent Care	Ward 11B	Severe harm - permanent or long term	Yes	Completed - submitted to CCG 27/04/2022
Patient Fall	Urgent Care	Ward 14B	Severe harm - permanent or long term	Yes	Completed - submitted to CCG 09/05/2022
Patient Fall	Urgent Care	7B	Severe harm - permanent or long term	Yes	Investigation underway - Due at CCG - 05/07/2022
Aspiration	Urgent Care	Accident & Emergency	Death as a direct consequence of the incident	Yes	Investigation underway due at CCG - 03/08/2022
Stillbirth	Women & Children's	Delivery Suite	Moderate short term harm need further treatment / procedure	Yes - Agreed extension	Completed - Submitted to CCG 27/08/2021
Failure to follow up (Reg 28)	Women & Children's	Paediatric Outpatients	Death - Unrelated	Yes	Completed - submitted to CCG 29/07/2021
Baby transfer for cooling	Women & Children's	Delivery Suite	Low harm - minimal harm patient required extra observation or minor treatment	Yes	Completed - submitted to CCG 12/08/2021
Birth Injury	Women & Children's	Delivery Suite	Death as a direct consequence of the incident	Yes - Extension agreed	Completed - Submitted to CCG 04/02/2022
Maternity Unit Closure	Women & Children's	Delivery Suite	Low harm - minimal harm patient required extra observation or minor treatment	No	Report due at CCG - 08/09/2021 - Submitted 22/09/2021 - No agreed extension logged on Datix?
Incorrect use of equipment	Women & Children's	Delivery Suite	Severe harm - permanent or long term	Yes	Completed - Submitted to CCG 10/09/2021
Baby transfer for cooling	Women & Children's	Neonatal Unit	Moderate short term harm need further treatment / procedure	Yes	Completed - Submitted to CCG 03/11/2021
Maternity Unit Closure	Women & Children's	Delivery Suite	No harm caused	Yes	Completed - Submitted to CCG 18/01/2022

Maternal Death	Women & Children's	Delivery Suite	Death as a direct consequence of the incident	Yes	Investigation underway - Due at CCG - 11/07/2022

1.11. Serious Incidents Submitted to the CCG

Throughout 2021/22 the Trust continued to investigate and review SIs as per the SI National Framework. During the reporting period, 100% of SI reports were submitted to the CCG.

	2021						2022				Grand Total
	QTR 1 21/22		QTR 2 - 21/22			TR 3 - 21/2	QTR 4 - 21/22		QTR 1 - 22/23 - To date		
	Apr	May	Jul	Aug	Sep	Nov	Jan	Feb	Apr	May	
Planned Care			1	1				1			3
Urgent Care	3	1			2	2		1	2	1	12
Women & Children's			1	2	2	1	1	1			8
Grand Total	3	1	2	3	4	3	1	3	2	1	23

Assurance – There is a robust process in place to ensure that serious incidents are reported on StEIS within the required time period as set out in the NHS Serious Incident Framework. Furthermore Fig. 9 shows good compliance with investigation timescales supporting a commitment to meeting internal and external performance measures.

1.12. Lessons Learned / Actions

Key learning identified from incident investigation is shared with staff members in the Integrated Governance Learning Bulletins. Some of the key learning points can be seen in the table below which have been extracted from the monthly learning bulletins provided to the Trust staff.

Lessons Learnt	Steps taken
It was identified that there was a requirement to review and formalise guidance relating to the management of nasogastric (NG) tubes.	• Staff placing NG tubes are to ensure the guide wire is removed once the tube is in place and has been checked. • The Trust reviewed its Local Safety Standards for invasive procedures (LocSSIPs) for the placement of NG tubes to prompt staff on the removal of the guide wire. • The checklist for this procedure has also been revised.

There was a requirement to improve communication with regards to discharge plans.	• The Trust developed the Communication Care Planning Tool which included a section for communication between clinical teams and with patients and their relatives/carers.
There was a requirement to reduce harm as a result of inpatient falls	• The Trust reinstated the Falls Prevention Working Group. The group monitors performance against the Falls Prevention Improvement Plan and regularly updates the plan with actions arising from new learning.
There have been a number of pressure ulcers with contributory factors identified as being patients making unwise decision about re-positioning.	• There is a review of guidance in relation to when/how staff should escalate if they are unable to reposition patients.
There was a lack of knowledge in relation to managing patient's property when they become an inpatient at the Trust.	• It was identified that there was a requirement to revise the Trust Policy for Managing Patient Property as there have been a number of issues in relation to this. The Policy was revised by the Assistant Director of Integrated Governance.

1.13. Overdue Incident Actions

Actions arising from incident investigation should be seen as essential drivers for improvements to patient safety. Those actions not completed may have serious implications for patients in the future and should be openly discussed within the Business Unit. In Q1 of 2022 there has been a large amount of incident actions overdue due, with the biggest rise seen in MEC, some of this will be due to busy winter pressures. However, these overdue actions are being addressed by the Scrutiny and Assurance oversight group and performance management of overdue actions will be monitored for assurance at Quality and Safety Committee on a quarterly basis. The table below shows the number of overdue actions for each Business Unit.

Incident actions overdue - End of each QTR					
Business Unit	**QTR 1 - 2021/22**	**QTR 2 - 2021/22**	**QTR 3 - 2021/22**	**QTR 4 - 2021/22**	**QTR 1 - 2022/23 - To date**
MEC	**420**	**396**	**375**	**450**	**484**
Women & Children's	**50**	**57**	**54**	**52**	**44**

Planned Care	**51**	**35**	**19**	**29**	**48**
Integrated Governance & Quality	**12**	**13**	**11**	**10**	**10**
Clinical Support Services	**21**	**12**	**5**	**8**	**8**
Medical Director	**6**	**5**	**5**	**5**	**5**
Estates & Facilities	**6**	**3**	**1**	**0**	**1**
Corporate Governance	**0**	**0**	**1**	**0**	**0**
Performance	**1**	**0**	**0**	**0**	**0**
Grand Total		**521**	**471**	**554**	**600**

Assurance **–** Whilst there are mechanisms in place to identify and monitor overdue incident actions, there continue to be significant delays in closing actions. It is noted that there are gaps in assurance and there should be consideration to manage this issue through the Risk Register.

The Trust has recently established a monthly Scrutiny and Assurance Group whose responsibility will be to monitor the progress, evidence and assurance relating to actions arising from Incidents, Complaints, Risks and CQC concerns. Regular updates on progress on actions will be made to QSC.

1.14. HFC (Harm Free Care Group)

The Trust Harm Free Care Group have the responsibility for reviewing 5 Day Rapid Reviews, Pressure Ulcer Rapid Assessment Tools, Grade 2 Pressure Ulcer RCAs. They also have the responsibility for making decisions regarding serious incident declaration. The Harm Free Care Group continues to meet weekly to ensure timely decision making with regards to incidents.

1.15. SIRG (Serious Incident Review Group)

The Trust continues to monitor serious incidents through the Serious Incident Review Group which meets weekly. In addition to the serious incidents the group review Moderate harm incident reports that are not discussed at the Harm Free Care Group meeting. SIRG is responsible for the approval of final investigation reports and the associated actions plans. The meeting is chaired by the Deputy Director of Quality, Risk and Assurance and attendance is required by those involved in the investigation and creation of the report. Once a report is approved the responsibility for the management of the action plan passes back to the CBU; assurance and closure of actions is monitored through the Trust Scrutiny and Assurance Group.

1.16. Human Factors Training

The Assistant Director for Integrated Governance in collaboration with Patient Safety Managers and the Clinical Risk Managers have rolled out Human Factors training across the Trust. The sessions cover the principles of Human Factors in healthcare and are aimed at all staff. The training has had excellent feedback and has been praised by AQUA for the content and delivery. Furthermore, the Trust has recently been nominated for a HSJ (Health Services Journal) award in Human Factors. It is a key component of a safety culture to understand how humans interact with systems and processes and this training is a key step for the Trust in understanding the significance of applied human factors. This training will continue to be delivered and staff members are encouraged to attend.

1.17. Incident Management

The Head of Risk in conjunction with the Assistant Director of Integrated Governance has developed a Trust Wide Training proposal for incident management training. The Trust has never had a comprehensive training programme for incident management and this will be an opportunity for staff at all levels to access training relevant to their job role. The training proposal is a working companion to the Human Factors training, and forthcoming Incident Management Framework as it ensures an applied approach to theory and uses real life incidents as discussion points. A training needs analysis is currently being developed and it is anticipated the training will commence in August 2022. In the meantime, focused incident management training has been delivered in Maternity Services, some corporate services and some sessions have commenced in MEC.

1.18. (IMF) Incident Management Framework

The Incident Management Framework (IMF) was developed to combine both the incident management strategy and incident management policy. The IMF aims to have all relevant information for staff with the responsibility for incident management in one document. Roles and responsibilities are made clear and there is supplemental guidance relating to the forthcoming Patient Safety Incident Response Framework (PSIRF). The document is comprehensive and easily accessible and has been approved by the clinical business units; it is currently in the wider consultation phase with the Executive Team.

1.19. Establishment of Datix Improvement group

The Datix improvement group was established to allow key stakeholders to provide feedback and suggestion on ways to improve the Datix system for end users.

Discussions at this group so far have been around implementation of a new form for the safeguarding team to use to enable digital referrals, instead of paper based, amendments to the different levels of Datix forms across all modules. The Datix improvement group continues to meet and discuss issues, make improvements to the Datix system.

1.20. Datix training

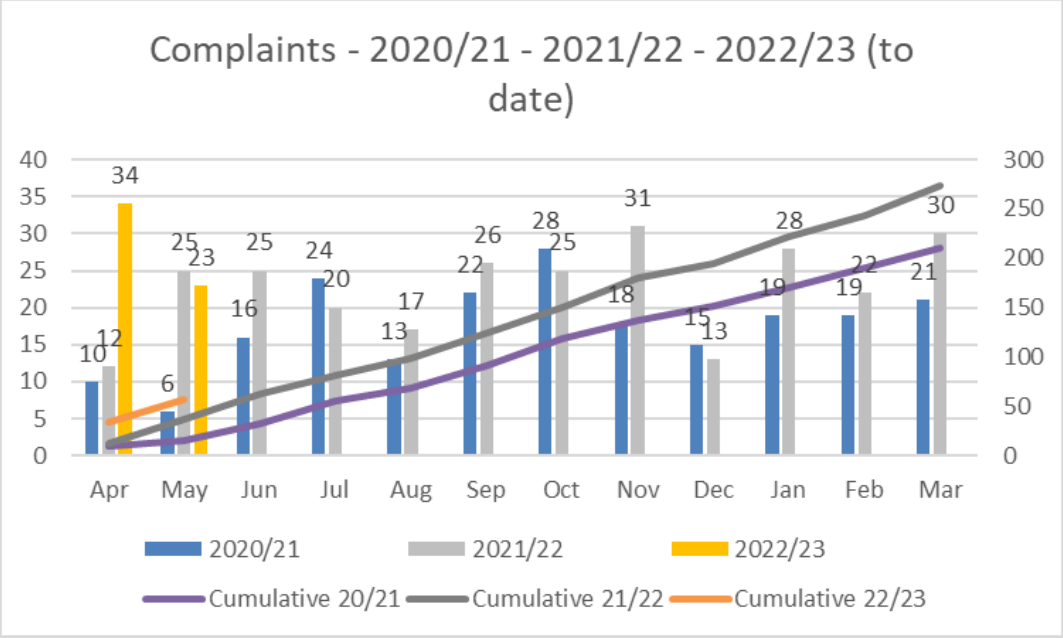
The trust has undertaken four sessions of Datix training in the Current year to date, The training was well received, and feedback was that staff felt more informed and confident in using the system after this training. The team are continuing to roll out training across Trust in 2022.

2. COMPLAINTS MANAGEMENT

2.1. Complaints

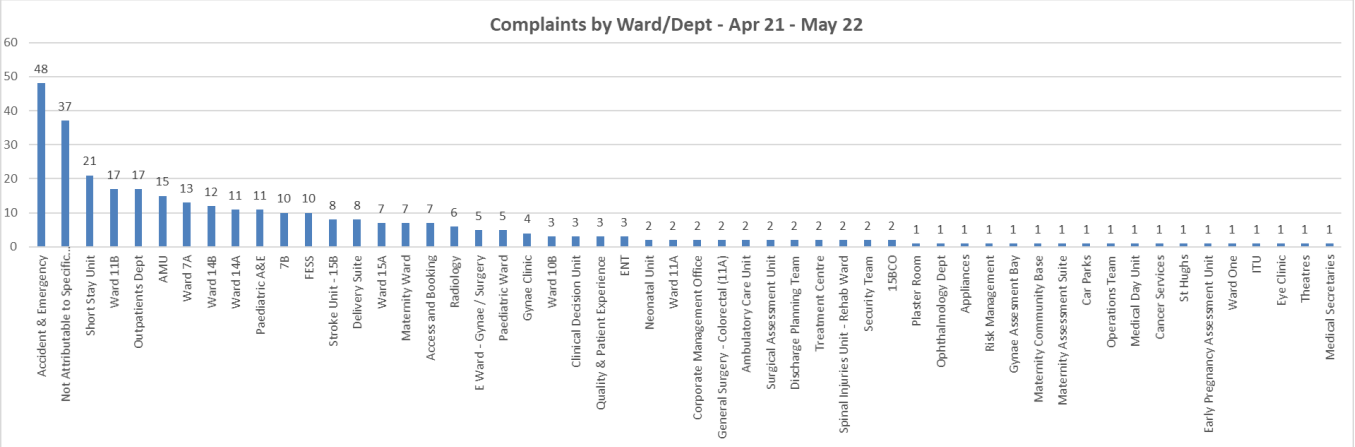
There has been a 39% increase in the number of complaints received in 2021-22 compared to 2020-21. This increase in complaints is reflective for the wider NHS and is driven by the challenges face by Medicine and Emergency Care performance.

Complaints received Apr 21 – May 22



2.2. Complaints by Location

The chart below shows the distribution of all complaints received in QTR 3 - 2021/22 by ward or department. The largest number of complaints received have been in relation to the Accident and Emergency department. In response an enhanced PALS officer role has been introduced to address any concerns and to de-escalate those that may result in a complaint.



2.3. Complaint Subjects and Outcome

All complaints are categorised by the subjects and sub-subjects contained within them therefore complaints can contain multiple subjects. The most common subjects seen were in relation to clinical care, communication and staff attitude/behaviour. The majority of complaints were registered in Medicine and Emergency Care and is reflective of the sustained challenges in Emergency Care. The table below gives an overview of those complaints, upon closure that had aspects of service provision or care when improvements were required.

	Not Upheld	Partly Upheld	Upheld	Grand Total
Medicine and Emergency Care	**10**	**24**	**9**	**43**
Women & Children's	**1**	**3**	**4**	**8**
Planned Care	**1**	**6**	**1**	**8**
Clinical Support Services		**1**		**1**
Integrated Governance & Quality	**1**			**1**
Grand Total	**13**	**34**	**14**	**61**

2.4. Complaint Performance

The table below shows the average number of working days between complaint receipt (and closure, for all complaints closed in QTR 3 2021/22. The agreed timescale for Level 1 and 2 concerns/Info requests is 5 working days. The agreed timescale for Level 3 and above complaints is 40 working days. In quarter 3 this target has not been met possibly due to high levels of activity and vacancies within the team. Performance is monitored through the complaints team, patient experience group and CBU governance processes. A new complaints managers was appointed in Q4 2021-22 and is developing actions to improve performance within the current year.

	QTR 1 - 2021/22	QTR 2 - 21/22	QTR 3 - 21/22	QTR 4 - 21/22	QTR 1 - 2022/23 - To date
Level 1 (Information Request/Suggestion/Concern/Complaint)	**1**	**3**	**3**	**1**	**1**
Level 2 (Concern/Complaint)	**4**	**10**	**12**	**6**	**1**
Level 3 (Concern/Complaint)	**44**	**51**	**47**	**24**	**0**
Level 4 (Complaint)	**38**	**52**	**21**	**46**	**N/A**
Total average days to close - Level 3 & above – Complaint	**43**	**51**	**46**	**24**	**0**

2.5. Complaint Actions

By the end of the Quarter 4 there were 88 overdue actions which has shown a positive decrease, the number of actions has gone up with the rise in complaints seen in the latest quarter.

Complaint actions overdue at end of each QTR					
Business Unit	**QTR 1 - 2021/22**	**QTR 2 - 2021/22**	**QTR 3 - 2021/22**	**QTR 4 - 2021/22**	**QTR 1 - 2022/23 - To date**
Urgent Care	**95**	**48**	**54**	**53**	**65**
Planned Care	**3**	**1**	**3**	**4**	**4**
Women & Children's	**26**	**25**	**35**	**27**	**28**
Clinical support services	**2**	**2**	**2**	**2**	**2**
Estates & Facilities	**1**	**0**	**0**	**0**	**3**
Integrated Governance & Quality	**3**	**3**	**3**	**2**	**3**
	0	**0**	**1**	**0**	**0**
Grand total	**130**	**79**	**98**	**88**	**105**

Assurance – Whilst there are mechanisms in place to identify and monitor overdue complaint actions, there continue to be significant delays in closing actions. In response to delays in closing actions, this will be monitored through the newly established Scrutiny and Assurance Group which will be held monthly.

2.6. Lessons Learned / Actions

Key learning identified from incident investigation is shared with staff members in the Integrated Governance Learning Bulletin. Q3 saw a number of incidents investigated where learning required widespread circulation. Some of the key learning points can be seen below.

Lessons Learnt	Steps taken
Ongoing challenge of Communication with patients, relatives & carers	An emphasis on how we communicate with patients, relatives and carers has continued during the ongoing challenges of the pandemic. The lack of opportunity for visiting can create worry and angst amongst relatives when they are unsure of patients' current prognosis. The Trust continues with a range of activities to support proactive enhanced communication with families/carers, zoom calls, letters to loved ones and the pilot of a new communication care plan to support.
Management of patient property within A&E	The presence of an enhanced PALS officer within the Accident and Emergency department has led to the implementation of a new system to manage patient property. There has also been a review and re-design of the Trust wide Patient Property Policy.
Patient's / NOK / Relatives not receiving updated during COVID19 Pandemic (Due to restricted visiting at Trust sites)	A new SOP (Inpatient communication plan) has been implemented to support staff in providing updated information to patient and their relatives whilst in our care.
Some patients not receiving correct dietary requirements as this was not included in the nursing proforma	Nursing documentation is being reviewed by the Assistant Director of Safeguarding to ensure that dietary requirements are included in future documentation.

Lessons learned are shared at:

- Ward and Clinical Business Unit (CBU) meetings

- Board via patient stories
- Via Lessons Learnt Slides

2.7. Patient Advice Liaison Service (PALS)

PALs contacts received from April 21 - May 22.

	2021/22				2022/21	Grand Total
	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	
Clinical Support Services	179	184	160	175	83	781
Estates & Facilities	114	131	103	127	120	595
Executive Management	86	69	77	106	32	370
Finance	58	38	39	37	28	200
Human Resources	30	20	19	15	12	96
Integrated Governance & Quality	36	20	21	7	7	91
Non Trust Location	13	8	13	9	8	51
Performance Division	4	3		2	1	10
Planned Care	1	1	2			4
Urgent Care	2	2				4
Women & Children's	1			1		2
Grand Total	524	476	434	479	291	2204

Actual patient numbers do not account for the multiple contacts PALS may have with a contact until the issue is resolved.

2.8. Compliments

	2021/22				2022/23 -To date	Grand Total
	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	
Planned Care	187	234	199	148	75	843
Urgent Care	44	72	62	72	56	306
Women & Children's	19	15	4	10	4	52
Integrated Governance & Quality	1	1	8	12	3	25
Clinical Support Services	3	6	3	8	4	24
Estates & Facilities	2		5	1		8
Human Resources					1	1
Trust wide - Multiple CBU's					1	1

Executive Management		**1**				**1**
Non Trust Location					**1**	**1**
Corporate Governance				**1**		**1**
Grand Total	**256**	**329**	**281**	**252**	**145**	**1263**

A significant amount of compliments go unrecorded as they will be informal gifts and compliments to ward staff for example. The Trust is considering we can capture as many compliments as possible.

3. RISK REGISTER

3.1 Risk Management

Responsibility for risk management lies with the Deputy Director of Quality, Risk and Assurance and processes continue to be reviewed by the Assistant Director of Integrated Governance (ADOIG). Improvements have been made during 2021/2022 in the quality of risk updates through dedicated training provided by the Integrated Governance Team to the CBUs. Reporting of overdue risks has also improved with the Trust reporting overdue risks at 11% on average over the last 3 months. At the end of Q4, there were 21 risks on the risk register with an overdue review date out of 141 risks that were open and approved on the risk register. In the last reporting quarter there were (98) overdue actions, however this has reduced to (64) overdue in the current quarter, a decrease of (34) risk actions.

Heat Maps are reviewed at Risk and Compliance Group to highlight the distribution of individual risks and scores per CBU. There are currently 7 risks rated as extreme for the organisation with regular updates to both Executive committee as well as review at Risk and Compliance Group.

The majority of moderate and high risks are currently open in Planned Care, MEC and Clinical Support Services. This has been consistent when compared to the risk management in the previous year 2020-21 given the bulk of patient activity in the three clinical areas. Finance currently hold the highest number of risks from a corporate perspective reflecting the financial challenges the Trust is currently under.

Quality improvements have been made to regular risk reporting with the format of the Risk and Compliance Group being reviewed by the Chair, Deputy Chair and the ADOIG.

Training on active risk management has been delivered to the CBUs as well as the governance leads throughout the year, which was well received. Throughout the year there have been multiple training sessions delivered to individuals who have booked on the course and communication has gone to staff about the e-learning which is also available via the Health Education England website. The ADOIG is currently assessing a digital training package, as well as supporting the CBU's Patient Safety Managers with their development.

3.2 Overdue Risk Actions

Risk Actions overdue at end of QTR					
Business Unit	QTR 1 - 2021/22	QTR 2 - 2021/22	QTR 3 - 2021/22	QTR 4 - 2021/22	QTR 1 - 2022/23 To date
Urgent Care	17	41	48	26	36
Integrated Governance & Quality	9	4	12	3	5
Executive Management	2	8	12	2	5
Finance	5	9	7	8	9
Clinical Support Services	3	4	6	0	4
Human Resources	5	7	5	0	0
Planned Care	1	1	3	0	2
Women & Children's	2	2	3	1	0
Estates & Facilities	7	1	2	0	1
Medical director	3	0	0	0	0
Grand Total	54	77	98	44	64
	➲	⬆	⬆	⬇	⬆

Assurance- Risk Management actions are regularly discussed as the Trust's Risk and Compliance Group (RCG) and are challenged and reviewed each month when it meets. Since the re-launch of this group, along with a new chair and new report management there has been an improvement in the number of overdue actions and the response of their management. This continued with the implementation of the new Scrutiny and Assurance Group which will regularly monitor these actions and support the CBU's with the management and quality of these.

3.3 Risk Management Framework (RMF)

As with the IMF, the Risk Management Framework (RMF) was developed to combine the Risk Management Strategy and Risk Management Policy. The principles of the framework are the same as the IMF in that it provides clear roles and responsibilities with additional guidance for staff with the responsibility for risk management. The RMF has been through a wide consultation phase and has been approved; the document is in the process of being published to the document management system.

4. CLAIMS AND INQUEST MANAGEMENT

Clinical Negligence, Public Liability, Employers Liability Claims settled from 1 April 2021 to 31 December 2021

4.1. Clinical Negligence

Trust Reference	Date claim opened	Date Claim Closed	Speciality	CBU	Learning theme	Total cost of claim
RM012/1920	28/01/2019	17/02/2022	General Surgery	Planned Care	Failure to arrange surgery and colostomy	£166,226.80
RM187/1920	14/05/2020	20/05/2022	Radiology	Clinical Support Services	Failure to identify tumour when interpreting MRI scan	£61,614.70
RM100/1920	25/09/2019	03/03/2022	A&E	Urgent Care	Inadequate care and assistance resulting in a fall	£24,459.00

RM123/1920	20/11/2019 (received to Trust 03/11/2019)	17/02/2022	Radiology	Clinical Support Services	Delay diagnosis	£1,216,831.80
RM025/1819	24/05/2018	03/03/2022	General Surgery	Planned Care	Failure to perform gastroscopy which delayed diagnosis of duodenal ulcer	£59,596.00
RM016/1920	11/02/2019	09/05/2022	Radiology and General Surgery	Planned Care	Failure to review claimant following x-ray / arrange surgical intervention	£27.796.75
RM080/1920	29/07/2019	17/02/2022	Women & Children's	Midwifery	Failure to monitor suspicious CTG resulting in suboptimal care during delivery	£0.00 ***
RM067/2021	10/02/2021	17/02/2022	A&E	Urgent Care	Management of sepsis leading to death	£17,293.40
RM092/1617	06/09/2016	07/04/2021	Gastroenterology	Planned Care	Fail/Delay diagnosis	£86,027.51
RM171/1617	20/03/2017	08/04/2021	Vascular	Planned Care	Fail to act on symptoms	£363,695.86
RM083/1718	02/02/2018	15/04/2021	Gynaecology	Women & Children	Alleged failure to diagnose cancer	£7,693.67*
RM011/1718	24/05/2017	19/04/2021	Emergency Medicine	MEC	Delayed cancer diagnosis	£47,007.00
RM020/1617	27/04/2017	20/04/2021	Orthopaedics	Planned Care	Failures during hip replacement	£421.60**
RM105/1920	07/10/2019	26/04/2021	Maternity	Women's & Children	Failure to test for 12 week chromosomal issues	£1,000.00*

RM113/1920	28/10/2019	04/05/2021	Maxillo-Facial	Planned Care	Failures during wound closure procedure	£15,932.00
RM072/1718	22/12/2017	25/05/2021	Orthopaedics	Planned Care	Alleged failures during hip replacement	£211.10* (no formal claim instigated)
RM051/1617	12/05/2016	25/05/2021	Orthopaedics	Planned Care	Alleged failures during hip replacement	£225.60* (no formal claim instigated)
RM096/1920	10/09/2019	08/06/2021	Orthopaedics	Planned Care	Failure to undertake post operative x-ray	£25,779.00
RM064/1415	28/08/2014	11/06/2021	Urgent Care	MEC	None – Claimant's claim failed	£92,098.75
RM055/1516	13/10/2015	15/06/2021	Ophthalmology	Planned Care	Failure to identify foreign object in eye	£292,719.60
RM054/1819	31/08/2018	05/07/2021	Orthopaedics	Planned Care	Failure to identify deformity developing	£78,686.9
RM077/1819	19/10/2018	05/07/2021	Nursing	Urgent Care	Failure to identify pressure sore	£29,624.00
RM076/1819	18/10/2018	04/08/2021	A&E	Urgent Care	Alleged failure to prescribe	£1,872.00*
RM095/1920	05/09/2019	20/07/2021	Orthopaedics	Planned Care	Alleged failures during knee replacement	£2,350.00*
RM145/1617	31/01/2017	28/07/2021	Maternity	Women & Children	Multiple failings during and after delivery	£147,485.47
RM041/2021	28/10/2020	12/08/2021	A&E	Urgent care	Alleged delay to refer	£1,830.00*
RM085/1718	09/02/2018	09/08/2021	Gastroenterology	Planned Care	Fall whilst an inpatient	£33,190.2
RM120/1617	17/11/2016	16/08/2021	Cardiology	Planned Care	Alleged failings to	£10,038.10*

					identify coronary and/or neurological injures following cardiac surgery	
RM084/1718	08/02/2018	01/09/2021	A&E/MSK	MEC/Planned Care	Alleged failings to diagnose	£20,022.10*
RM061/2021	11/01/2021	01/09/2021	Gastroenterology	Planned Care	Fall whilst inpatient	£18,700.00
RM140/1920	15/01/2020	02/11/2021	Anaesthetics	Planned Care	Alleged failings relating to consent form	£2,544.00*
RM094/1920	04/06/2019	11/11/2021	A&E	Urgent Care	Failure to diagnose disc prolapse	£67,353.10
RM023/2021	13/08/2020	09/03/2021	A&E	Urgent Care	Failure to recall after identifying fracture	£23,743.50
RM008/2021	01/07/2021	02/12/2021	Maternity	Women & Children	Alleged failure to diagnose pressure ulcer	£3,645.10*
RM103/1819	12/12/2018	02/12/2021	Maternity	Women & Children	Failure to remove placenta in timely manner	£35,070.00
RM005/1920	14/01/2019	17/12/2021	A&E	Urgent Care	Failure to treat finger appropriately	£56,050.00

**Settled Trust lawyer's costs only – no damages paid to Claimant by Trust as case was discontinued/abandoned by Claimant*
***Related to Hip/Knee*
**** Early Notification Scheme – Pre-emptive scheme provided by NHSR to deal with neonate cases when a baby will have required cooling after birth.*

TOTAL: £3,011,087.36

4.2. Employer's Liability

Trust Reference	Date claim opened	Date Claim Closed	Location	CBU	Cause	Total cost of claim
RML013/1617	30/09/2016	17/02/2022	Stroke	Urgent Care	Injuries when pushed by patient relative	£19,834.10
EL006/2021	03/09/2020	12/08/2021	Laundry	Corporate	Fall into defective drainage gate	£4,158.26
RML001/1819	27/04/2018	25/10/2018	Catering	Corporate	Burns whilst in kitchen	£4,729.00
RML003/1920	09/05/2019	17/10/2019	G Ward	Planned Care	Slipped on urine on floor	£14,727.00
RML001/1920	27/03/2019	07/10/2021	Lift, main corridor, Southport	Corporate	Faulty lift dropped from 1st floor to ground floor	£7,249.00
RML009/1718	01/02/2018	25/10/2021	Urology Ward, Ormskirk	Planned Care	Faulty fire door shut without warning	£28,798.56

TOTAL: £79,495.92

4.3. Public Liability

Trust Reference	Date claim opened	Date Claim Closed	Location	Cause	Total cost of claim
PL01/2122	08/04/2021	25/10/2021	X-Ray Dept, Ormskirk	X-ray guidance arm struck patient in face causing injury	£3,022.00
PL02/2122	09/09/2021	03/03/2022	A&E main hall entrance, Southport	Patient slipped on wet floor	£0.00

TOTAL: £3,022.00

GRAND TOTAL: £3,093,605.28

4.4. Inquests

Between 1st April 2021 and 31st May 2021 there were 33 inquests listed. HM Coroner is slowly dealing with the backlog of cases and HM Coroner for Sefton, Knowsley and St Helens is still holding Inquests virtually via Microsoft Teams. Of the 33 inquests that were listed, the Coroner's conclusions are as follows:

- ***Narrative conclusion*** – 16 cases (where the death does not fall cleanly into the Coroner's 'standard' conclusions and more commentary is needed from them to suitably detail how the death came about)

- ***Accidental death conclusion*** – 5 cases;

- ***Natural Causes conclusion*** - 4 cases;

- ***Misadventure conclusion*** – 4 cases (when a death arises from some deliberate human act which unexpectedly and unintentionally goes wrong)

- ***Industrial Disease conclusion*** – 1 case;

- ***Drug Related conclusion*** – 1 case.

- 1 case was discontinued by the coroner as the inquest was not deemed necessary and a further case resulted in the inquest proceeding but without the Trust being required to be an Interested Person.

- 1 case resulted in the Coroner issuing a Regulation 28 Prevention of Future Deaths Report. The Regulation 28 report was issued by the Coroner to the Trust. The Coroner gave 2 actions for the Trust to take to prevent future deaths. The 2 actions attributed to the Trust where on the communication to both patients' families and with communication with other providers when there is a transfer of care following referral. The Trust has worked closely with other providers in developing a network where care which is shared across organisations can be reviewed as well as how we communicate information to patients and their families.

5. CENTRAL ALERTING SYSTEM (CAS)

The Trust has robust systems in place to monitor and manage Safety Alerts. Performance remains at 100% and is supported with an internal CAS Policy which was reviewed and updated in Q4. There were 78 alerts received (which includes medication alerts) in the reporting period with 111 closed. Due to a data cleansing exercise and moving from a spreadsheet system to the Datix system, more CAS alerts were closed than received. Currently there are 2 ongoing alerts being managed in the Trust that remain within the specified timeframes.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	26 June 2022
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Guardian of Safe Working
The Committee were informed that the Guardian of Safe Working post remains unfilled. The Medical Director has been exploring a variety avenues to address the issue.

ADVISE

Equality, Diversity and Inclusion Thematic Presentation
The Committee were presented with the monthly presentation pertaining to Equality, Diversity and Inclusion, and race. A thorough and deep discussion was undertaken by the members related to unconscious bias and equality training, and data of the Trust's demographic and aligning staff representation. Gaps were additionally identified during discussions, leading to further actions to be undertaken outside of the Committee.

Board Assurance Framework (BAF) – Strategic Objectives 4 & 5
The Committee noted and were assured by the recently reviewed BAF documentation and updates included.

PDR Compliance
Compliance for PDRs has dropped again in month. Actions have been taken to increase performance, such as: setting trajectories for the CBUs; sending weekly PDR compliance lists to individual managers; and providing how-to guides on how to accurately upload and record PDRs on ESR. PDR compliance is being addressed at team meetings by the COO and HR Business Partners. Compliance has entire Executive buy-in for improvement.

HCA Vacancy Rates
Despite the vacancy rate decreasing for HCA's, the Trust remains aware that the salary for this staff group is not competitive against other companies. The organisation is currently putting in place an improved support package to HCAs for retention purposes.

Employee Relations
It was reported in month that the Trust has 10 live Employee Relations cases, five Employment Tribunals and 11 Just and Learning Culture cases. There was a brief discussion related to the disproportion of staff involved in these cases, related to age and gender.

University of Liverpool Quality Visit
The Committee was advised that despite some outstanding actions, the University recognised the work undertaken by the Trust to improve its medical education services.

ASSURE

Mandatory Training Compliance
Compliance for Mandatory training has increased again in month.

Safe, Effective, Quality Occupational Health Service (SEQOHS) Report
The Trust was successful in its reaccreditation of SEQOHS in year.

New Risks identified at the meeting: None
Review of the Risk Register: Yes

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	27 June 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Trust is reporting a £3.6m deficit at month 2, which is in line with the financial plan. £7.6m of the £7.8m original CIP target is RAG rated as green and at month 2 the Trust is delivering to plan. The ICS has not yet shared any calculations with regard to how ERF will be calculated in 2022/23, but given current performance, this is an area of financial risk for the organisation. The other risk to delivering the plan is the continued non elective pressures, which has meant that the winter escalation wards are still open.
- The final financial plan for 2022/23 was signed off by the Chief Executive and submitted on 20 June. The plan delivers a deficit of £14.1m. To deliver the plan there is a requirement for a 5% CIP in year.
- A&E performance continue to improve in May 2022 but was below the national standard. Compares positively to peers and top quartile nationally. The Trust has continued to see improvement with 12 hour duration breaches.
- Whilst still below the standard, the Trust has seen improvements across the 14 day and 104 day cancer standards. 62 day performance is significantly below the standard.

ADVISE

- Work relating to the cross-site switches and VPN replacement has been completed, as part of the short term network remediation plans. The IT team will be monitoring the improvement to the packet loss and will report back at the next meeting. Planning will now commence for the full replacement of the network infrastructure.
- The condition survey on the chimneys at the energy centre at Southport shows that all four needs replacing. The funding for this scheme is built into the 2022/23 capital programme, and an agreement on the risk share with the contractor, is currently being negotiated.
- Stroke Final Business Case (FBC) has been produced to support the North Mersey Service change and is going to Exec Committee on the 28 June for approval to progress to Strategy and Operational Committee on 6 July for final Trust approval.
- Whilst May 2022 had seen the Trust reduce Covid-19 positive admissions to just two patients, the number of patients was reported to be on the rise. Reported at 37 patients across two Covid-19 wards.

ASSURE

- The output from the recent 6 facet survey has been submitted as part of the ERIC return and shows backlog maintenance figures in line with information shared with the ICS and NHSE/I.
- A plan was presented to the Committee with regard to the National Cost Collection (NCC) due in August.
- Plans for how the £2.6m backlog maintenance funding agreed by the ICS, will be utilised, will be agreed at the Executive Committee on 28 June, and reported back at the next Committee.
- The Trust has had some recent success with recruitment of locums in Ophthalmology which will result in three Consultants and one SAS Doctor commencing with the Trust in the coming weeks.

• Collaboration discussions continue to be extremely positive with STHK and S&O • Improvements reported last month in endoscopy continued in May 2022, achieving 153% 2019/20 levels.
New Risks identified at the meeting: None
Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	June 2022
LEAD:	Anne-Marie Stretch

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Maternity Services – Insight Visit (06.06.22)

A regional Insight Visit is planned for 10 June 2022. This is an assurance visit by the regional maternity team. KLOE evidence has been collated in preparation and the biggest area of concern is the content of the minutes which does not appear to provide adequate scrutiny or support robust governance in place. Need to consider what development CBUs need.

Maternity Update (13.06.22)

Ockenden Assurance – Insight visit took place on Friday 10 June.

They were pleased to see Ockenden was included in appraisals and complimentary about AVP and noted the good relationships The visit began with a presentation which highlighted some really good areas, it looked at some of the challenges being faced in response to the Ockenden ii report. There was a tour of the unit and interviews with the teams, followed by a sense check about learning from the maternity incident. The visit was very thorough and in-depth and included a walk-through of the patient pathway for theatres. The staff were found to be welcoming, open and engaging.

The following issues were raised:

- Concerns raised about staffing overnight
- Curious about the Board structure with StHK and how Board reporting worked, NB advised she could address this if required.
- Maternity should be included in the escalation at bed meetings
- Potential under reporting of Serious Incidents.
- Obstetric lead requires a review of the number of PAs allocated
- Review of reporting lines for staff should be undertaken
- Lack of MDT approach and a feeling of hierarchical behaviour
- Quality of minutes did not reflect the detail of the conversations that had taken place
- Training data should be included on the Board report
- BSOT – obstetric tool they noted a separate room was required for triage

Following the visit LB, KC & LN are meeting again with the regional team on 15 June to present the action plan, progress on the immediate actions and provide further assurance in relation to the governance.

ADVISE

Items for Escalation from Silver Command (06.06.22)

KC noted that updated IPC guidance had been received which advised face masks did not need to be worn in any areas of the hospital. Andrew Chalmers was in the process of drafting updated comms.

Desktop Exercise – Network Outage (13.06.22)
Paul Chadwick attended the meeting and presented a 'Cyber Incident Response Exercise' this was aimed to provide the Executive Team with assurance of what to do should there be a network outage out of hours.

Core Switch Replacement Plan (13.06.22)
Paul Chadwick provided an update on the proposed plan to replace the unsupported cross site core switches. The proposed work would take place during the hours of 7pm on Wednesday 22 June to 7am on Thursday 23 June (12 hours in total). PC noted the core switch work is a critical progression to resolving the issues currently being experienced across the network and improve the cross-site network throughput.

Items for Escalation from Silver Command (13.06.22)
A review of the heatwave and thermal policy had taken place, Procurement had highlighted that there are delays with the ordering time of air-cooling systems

Update on Capital Bids (13.06.22)
Mark Hogg provided the Executive Committee with a high-level update on the progress of the business cases. Targeted Investment Fund (TIF) and Community Diagnostic Centre (CDC)

TIF – proposed order of investment:
Modular Unit on Helipad to temporarily house Ormskirk Endoscopy Service whilst existing Endoscopy footprint is renovated
Modular Unit at Southport to permanently house Southport Endoscopy Service
Additional CT scanner at Southport adjacent to existing CT with mobile on site to ensure service resilience
Relocate Therapy team to Ormskirk modular unit after Endoscopy returned to main hospital
Renovate Ward A to create a new treatment room

CDC
This bid will include both CDC and reconfiguration of the treatment rooms. There is some degree of flexibility on the digital costs, but it will be important to align some of the work schemes. MH pans to speak to Ian Triplow to confirm if the £600k for the CT scanner is a separate bid, if IT is happy with the £5.3m that is the bid that will be submitted.

Timelines are essentially the same, however if funding is approved it is unlikely that the work will be completed within the financial year.

Equality, Diversity and Inclusion Plan (13.06.22)
The Executive Committee was asked to support the recommendation for JMcL to be the Executive Sponsor for ED&I and the key areas of focus determined by the Special Interest Group (SIG) which are:

- Communication and engagement
- Deep dive review into shortlisting and onboarding stages of recruitment and selection
- Continue to build staff networks

Maternity Capacity & Demand Business Case

LB shared the business case for information but noted her concern that urgent progress is required to support progress of the business case. Discussion followed about the new maternity theatre model and the need to address the issues. The Executive Committee agreed that adverts could go out for the following posts pending the business case submission to the SOC for approval.

- Band 6 Scrub Nurse
- Band 3 HCA for theatre
- O&G Consultant
- Band 6 Midwife
- Band 3 HCA/MSW

Patient Experience Away Day (13.06.22)

Lovely feedback received. LB noted the session from Nina Mallorca was emotional, reflecting their experiences of Covid-19. There was an overwhelming feeling of comradeship. FES ward has gone from being the worst ward for falls to the best by having no falls for a month. It was a very inspiring day, and the quality of the presentations was excellent.

Policy Update (20.06.22)

NB presented the monthly Policy Update report which provided an overview of the management of Trust Policies and provided assurance to the Executive Committee on the work that was currently being undertaken to improve the position. NB advised that there had been a slight improvement (reduction) in the number of policies past their review date since May.

Stroke Services Update (20.06.22)

NR provided an update on Stroke services and advised that the full business case (FBC) was in final draft and the two trusts have gone through a check and challenge process with the CCG in advance of the FBC being submitted to the Trust Boards for approval. There had been a change in the S&O staffing model from the original pre-consultation business case (PCBC) due to an increase in the required bed numbers (14.5 beds has now increased to 17 beds), the acuity of patients at Southport and the need to extend the Specialist Nurse cover because of the increased number of suspected strokes who now self-present rather than arrive by ambulance. The FBC had seen a significant increase in revenue costs compared to the original PCBC which may result in further check and challenge as part of the ICB sign off process. A copy of the FBC was due to be presented Exec Committee next week ahead of being presented at SOC on 06 July.

ERIC Backlog Maintenance Submissions 2021/22 (28.06.22)

JMcL noted that the Trust is required to undertake a mandatory return on an annual basis and a 6 facet survey should be completed every couple of years, however we had not completed one until 2019. When JMcL joined the Trust, he wanted to get a real feel of what the position actually was. As part of the

conversation with NHSE/I a desktop review had been commissioned which identified a total backlog figure of £52.9m. There was only a limited amount of money available from the ICS and therefore the high and significant risk items are being considered:

- Fire Safety
- Primary Electrical Infrastructure
- Access Control
- Ventilation
- Building Management System
- Ward Upgrades Required

JMcL noted the importance of ensuring the Trust Board are fully sighted on the current costs to eradicate backlog maintenance across both hospital sites. NB suggested the ERIC backlog maintenance submission should be shared through FP&I to ensure visibility of high-level costs.

ASSURE

CIP Update (06.06.22)

JMcL advised CIP Council meetings are in the process of being arranged. Executive Deputies will chair with JMcL, LN & JR named leads. CBU FP&I meetings will take place on 16 June, Chrisella Morgan is currently reviewing the Covid spend.

Board Assurance Framework (BAF) update (13.06.22)

Good progress has been made and once final amendments have been made the updated BAF will be presented at Trust Board on 30 June for information and at SOC on 06 July for approval, as well as going via the assurance committees and Audit Committee.

New Risk identified at the meeting	None
Review of the Risk Register	